Gloucestershire Out of Hours

Inspection report

Unit 10 Highnam Business Centre
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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall. (Previous inspection November 2021 – Requires improvement)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Gloucestershire Out of hours on 22-23 November 2022. This was a follow up inspection due to the rating of Requires improvement and breaches of regulations at the previous inspection in November 2021.

How we carried out the inspection

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing
- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider
- Requesting the completion of a staff survey document
- Conducting site visits.

At this inspection, we found:

- Since the last inspection, improvements had been made to some processes including the reporting and reviewing of significant events and complaints. However, further embedding and development was required.
- Action had been taken to address shortfalls in sepsis training, however we found new issues with the lack of staff mandatory training oversight.
- Rota fill and staffing continued to contribute to delays in patient care and satisfaction. Patients experiencing delays were not always monitored effectively.
- Shortfalls in systems and processes had led to the service being unable to assure themselves of safe and effective care for patients.
- Risks to staff and patients were not always effectively managed in line with policy and guidance.

Overall summary

- Staff treated patients with respect and had access to appropriate guidance and support where needed.
- Improvements had been made to audits carried out on staff.
- There was mixed feedback regarding senior leaders, including communication. Staff did not always feel heard or consulted.
- The service promoted values, which staff were aware of, however leaders did not monitor this with a vision or strategy.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure sufficient numbers of suitable qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure care and treatment is provided in a safe way to patients

The areas where the provider should make improvements are:

- Complete risk assessments & any associated action plans in a timely manner.
- Develop a strategy for the service to be monitored in line with their values.

.Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC Inspection Manager, two CQC inspectors and a GP specialist advisor who visited the main location and two primary care centres where care and treatment was delivered.

Background to Gloucestershire Out of Hours

Gloucestershire Out of Hours is the registered location for services provided by Practice Plus Group Urgent Care Limited and provides out-of-hours primary medical services to patients in Gloucestershire when GP practices are closed.

The administrative base is located at:

Unit 10
Highnam Business Centre,
Highnam,
Gloucestershire
GL2 8DN

Gloucestershire is mainly rural with two major urban centres, Gloucester and Cheltenham.

The service is commissioned by Gloucestershire Integrated Care Board and covers a population of approximately 637,000 people across the county of Gloucestershire. Patients access the service via the NHS 111 telephone service. Patients may be seen by a clinician at one of the primary care centres, receive a telephone consultation or a home visit, from a clinician being driven by a driver in one of their fleet of 4x4 liveried vehicles, depending on their needs. The majority of patients access the service via NHS 111.

The service provides the clinical assessment service (CAS) for NHS 111, which was delivered from the administrative base, with some clinicians working remotely and other clinicians working at the primary care centres.

The out of hours service is provided from the administrative base and the primary care centres are located at:

Gloucester Royal Hospital, Great Western Road, GL1 3NN (6.30pm to 8am weekdays and a 24-hour service over weekends and bank holidays)

Cheltenham General Hospital, Sandford Road, GL53 7AN (6.30pm to 11pm weekdays and 8am to 11pm over weekends and bank holidays)

Dilke Hospital, Cinderford GL14 3HX (6.30pm to 11pm weekdays and 8am to 11pm over weekends and bank holidays)

Cirencester Community Hospital, Tetbury Road, GL7 1UY (6.30pm to 11pm weekdays and 8am to 11pm over weekends and bank holidays)

There are two further primary care centres not currently in use in agreement with the commissioner.

During the inspection we visited the Gloucester and Cheltenham sites.

The provider is registered to provide the following regulated activities:

Transport service, triage and medical advice provided remotely

Treatment of disease, disorder or injury.

Requires Improvement

Are services safe?

At the previous inspection in November 2021, we rated the service as requires improvement for providing safe services because:

- There were shortfalls in providing training in sepsis awareness.
- There were ineffective arrangements for planning and monitoring numbers of staff working (shift fill).
- Management of significant events were ineffective.

At this inspection, despite some improvements, we have continued to rate the service as requires improvement for providing safe services because:

- We found previous areas of improvement continued to be a challenge, for example, effective planning and management of staff cover (shift fill) and management of controlled drugs whilst in transit.
- We found new areas where improvement was required which included a lack of oversight in staff mandatory training oversight and medicines management. Recruitment was not always managed in line with guidance and risk assessments associated with staffing safety were not always considered.

Safety systems and processes

The service had systems to keep people safe, however these were not always effective. Patients were safeguarded from abuse.

- The provider conducted safety risk assessments and audits including fire, infection prevention and control and buildings safety. However, there were inconsistencies in how the actions were managed; for example, the fire risk assessment had a list of actions which had been appropriately assigned and completed by staff, but actions from a buildings safety risk assessment from 2018 had not been actioned and subsequently similar actions were identified again in 2022. For example, the lack of outside lighting, security cameras, lack of window restrictors and visual protection. Following increased staff safety concerns and an incident, some of these actions had been completed, including outdoor lighting and security cameras. The service sent evidence to us to demonstrate they had attempted to action this earlier however it had not been possible due to constraints with the building and land owner. This had not been effectively documented prior to our inspection to evidence a risk assessment or barriers to actioning.
- For buildings where patients attended, risk assessments were carried out by the hospital providers and copies were requested to be kept locally by this service.
- The provider had safety policies in place to protect patients and staff. We found staff shortages had caused an increase in unplanned lone working for staff. Whilst there was a lone working policy in place, we found evidence of staff who had worked alone who had not been risk assessed in line with the policy. We discussed this with leaders, who told us they did not consider temporary lone working or unplanned lone working staff to be lone workers. Following our inspection, we were provided with a generic risk assessment to cover unplanned lone working at the services hub, however staff were not aware of this and there were no lone worker risk assessments to cover the primary care centres (PCC). Lone working had been raised as a risk on the provider risk register following incidents of a clinician lone working whilst attending to unwell patients. Controls aimed to be in place had not always been followed; for example, clinical staff should not have been subject to any further lone working and the lone working policy in place to be followed.
- There were safeguarding policies and processes in place to keep patients safe. Although we found, out of 30 returned staff surveys, 17 could not correctly identify the safeguarding lead, staff we spoke to understood how safeguarding processes worked locally. Staff we spoke to had access to the details to escalate concerns in appropriate time frames and the safeguarding contact details were made available via the coordinator for staff to access throughout their shift.
- Staff training deemed as mandatory by the service included the appropriate safeguarding level for their role. We were provided with two training matrixes which monitored staff that were contracted to hours and self-employed medical

professionals. We found 24 out of a total 101 clinical staff did not have in date safeguarding children training at the time of inspection. We viewed quality assurance meeting presentations where this had been discussed and found there was no action taken to update the records. Following our inspection we were provided with further training matrixes that showed us out of 90 clinical staff members 23 (equivalent to 25% of the clinical workforce) did not have in date Level 3 safeguarding children training and 8 members (9%) did not have in date Level 3 Safeguarding Adults training. 11 clinical members of staff had been removed from the training matrix as they had not done a shift for longer than 6 months and therefore would not be able to complete shifts with the provider. Compliancy for safeguarding training amongst non-medical staff varied between 79% and 86% completion.

- There were inconsistencies on the completion of chaperone training for drivers and receptionists. Whilst drivers told us they did not routinely enter patient houses with the GP, they would chaperone at the clinician's request. Out of 14 drivers, 4 had not received chaperone training. Out of 20 receptionists, 14 had not received chaperone training. This was listed on the staff training record to complete.
- We found gaps in the recruitment of staff. The recruitment process included some information being held locally and some centrally to the provider network. We found some staff did not have occupational health checks in line with guidance. For example; the provider did not request to view the immunity status of staff who handled sharps boxes or may be required to chaperone or perform basic life support in a cardiac arrest. These staff had not had their immunity status viewed or discussed in line with The Green Book national guidance. We also found that during 'onboarding', self-employed medical staff were not required to submit evidence of their immunisation status. We discussed this with the human resources department who told us that they would not be qualified to understand immunity test result or vaccination history therefore ask staff to self-declare their history and that it is not in their policy or procedure to request immunisation history from non-clinical staff. Therefore, we could not be assured that possible infection control risk to staff or patients had been fully considered.
- We found some staff who had continued to be employed following the change in provider did not have all the recruitment documents in line with the provider policy. We raised this during this inspection and a note was placed into one of the GP's files to reflect they were happy with the individual's performance and would not be carrying some of the checks in retrospect. There was no risk assessment to accompany this.
- Staff professional registrations were monitored and were checked on an annual basis to keep oversight of professional standards and status.
- 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).
- We viewed infection prevention and control audits which had been completed for the appropriate sites. Infection prevention and control audits did not include a review of staff immunisation.
- The premises was clinically suitable for the assessment and treatment of patients. Facilities and equipment were safe and equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety, however these were not always effective.

- There were arrangements for planning and monitoring the number and mix of staff needed, but these were not always effective, which had contributed to delays in patients receiving timely care and treatment.
- We were not assured rota cover was being managed effectively. The service employed a rostering team, however due to various reasons this had not been consistently staffed. There was a high proportion of self-employed clinical staff compared to contracted staff who were not required to be available on a regular basis. We viewed coordinator logs and staff feedback which showed the planned rota was not always accurate; for example, edits were required as staff who were rostered to be in, didn't attend and those who hadn't been rostered to work did.

Requires Improvement

Are services safe?

- We looked at the rota between June 2022 and September 2022 and found there were inconsistencies in clinical rota coverage. We were told the service aimed to have a minimum of 4 clinicians, such as an ANP or GP overnight which included, cover at 1 PCC overnight, 1 triage clinician, 1 car overnight. The additional clinician would provider cover at a PCC between 11pm and on a car after 11pm. This was not in line with the expected minimum standard of the commissioner.
- The service has aimed for this since the decreased use of some PCC's and increased dependence of home visiting cars, which had been agreed by the commissioner.
- On our review, we found inconsistences in the overnight cover for a weekday (Monday to Thursday excluding bank holidays) and the amount of GPs available could vary from a total of 3, which would leave 1 after midnight, to a total of 8 overnight with 3 available from midnight. Advanced practitioners were employed to support GPs.
- We found examples where there was only 1 GP available after midnight. This had occurred on 4 occasions in June 2022, 7 occasions in July 2022, 7 occasions in August 2022 and 5 occasions in September 2022. Therefore we could not be assured there was consistent and sufficient GP rota cover.
- Where there were staffing concerns or excessive delays, this could be escalated to an on-call manager, who had oversight of neighbouring location demand under the same provider (The provider has multiple locations providing the same service). The national provider scale meant support could be given from neighboring services, however we were told by staff they had supported other services when the local area were already experiencing delays. Therefore, we could not be assured it was effectively implemented.
- The data shows there was no improvement in the amount of unfilled shifts since the last inspection, however it was now more consistently unfilled when compared to the service's key performance indicators.
  - At the last inspection, we found unfilled shifts on the rota ranged from 2% to 53% between November 2020 and October 2021.
  - During this inspection, we found unfilled shifts for all staff on the rota ranged from 15% to 43% between October 2021 and September 2022. More specifically between June 2022 and September 2022 the average percentage of unfilled rota was at 29%. This ranged from 24% to 43%.
  - At the last inspection we found unfilled shifts for clinical staff ranged from 3% to 50% between November 2020 and October 2021.
  - During this inspection, we found unfilled shifts for clinical staffed ranged from 25% to 39% between October 2021 and September 2022. More specifically between June 2022 and September 2022 the average percentage of unfilled rota for clinical staff was 27% This ranged from 23% to 32%.

- Since the last inspection, senior leaders told us they had recruited 54 new starters. However, overall staffing amounts had not improved. For example:
  - There was a reduction of 10 GPs from October 2021 and June 2022. Numbers were now 4 below what they were at the last inspection.
  - There was an increase in agency GPs since the last inspection between October 2021 and August 2022, but this returned to similar numbers again in September 2022.
  - There has been a reduction of 14 advanced practitioners between October 2021 and May 2022. There had been no improvement since May 2022.

- It had become standard rostering for face to face appointments to be available at Gloucestershire Royal Hospital Primary Care Centre (PCC) between 6:30pm and 8am and Cheltenham General Hospital until 11pm. As a replacement for other PCC sites being closed, the service aimed to have a home visiting car available, however this did not always occur due to difficulties with staffing shortages and rota fill.
- We received mixed feedback from staff regarding their induction to the service. We were told staff were given a presentation then had an opportunity to shadow shifts. However, there was an inconsistent approach to how these

shadow shifts were documented. We found there was not a standard way to document what an induction consisted of and when this had been completed. We were told clinical staff would not be able to start work for the service without a signed form to evidence they had completed an induction. The service was due to implement a new induction system for operational (non-clinical) staff, however this was not yet in place.

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Clinical staff had access to appropriate assessment tools to support their clinical rationale. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need.
- Systems that were in place to manage people experiencing long waits or those that had been inappropriately streamed into the service were not always effective. The provider had been implementing patient safety callers, who were non-clinical staff members, that aimed to contact patients who have been waiting longer than expected, since November 2021. These staff should then highlight calls to clinical staff if the patient had deteriorated. This was provided centrally on a national scale with some local staff also completing this role. The provider aimed to provide training, had implemented a local operating procedure and audited staff doing this. However, we found there were inconsistencies on when training had occurred, the completion of these calls at a national level and responsiveness of the clinicians once the calls were highlighted.
- Staff told us there were often calls outstanding on a Monday morning after weekend delays. We requested the volume of outstanding calls left to be triaged on a Monday for the 4 weeks prior to inspection. Outstanding numbers at 8am on a Monday varied from 93 calls, of which 27 were categorised as urgent, to 187 calls, of which 73 were categorised as urgent.
- The service employed clinicians to work a Monday morning to ensure the calls do not get passed back to GP in hours services. However, patients requiring a face to face appointment would be required to contact their own GP. The service did not routinely monitor to see how many calls were closed as a result of people finding alternative healthcare. We saw evidence of clinicians working mornings of other weekdays to assess outstanding calls.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. Clinicians were audited on a regular basis and this was fed back to clinicians to aim for an unified approach. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The system allowed for a patient's own GP to be notified of the out of hours consultations and staff had access to care records.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

Whilst there had been some improvement to managing prescription security, shortfalls in the systems and arrangements for managing medicines were still present.

- Since our last inspection in November 2021, there had been improvements to prescription security. Use was easily monitored and countersigned by non-clinical staff where appropriate.
- There were systems and arrangements for managing medicines including emergency medicines, however, they were not always effective. For example, the service utilised an external company and followed a procedure for monitoring controlled drugs and emergency medicines. However, following the procedure had left shortfalls in the monitoring of

emergency medicines. For example, at Gloucestershire Royal Hospital PCC, we found there was no Diazepam rectal solution (used to treat seizures) in line with their processes. This had gone unnoticed by staff due to the procedure used. Once highlighted, the service made contact with the medicines provider to source the medicine following this, however, we were not assured a similar event would not reoccur due to the current ineffective process in place.

- There had been improvements made to the management of controlled drugs whilst kept at the hub or Primary Care Centre's including countersigning of removal of the controlled drugs. This was in line with guidance.
- Arrangements were in place to ensure medicines were transported in vehicles however, systems to support the safe transport of controlled medicines were not always effective or in line with guidance. Following a significant event in May 2022 where the controlled drug was dropped and subsequently the ampoule was broken, the service were due to change their procedure. This had not been implemented at the time of inspection. Post inspection we were sent a draft version of the new Local Operating Procedure which still did not meet standard for the Home Office Guidance for the safe custody and controlled drugs and precursors in transit 2020.
- Emergency equipment and medical gases were checked by staff and shortages were escalated on a shift log.
- Leaders carry out monthly prescription audits. They told us they look for themes that were fed back to clinicians.
- Controlled drug audits were carried out. We found an audit from October 2020 where there had been a response which required action. Post inspection we were provided with evidence to demonstrate all follow up actions identified had been responded to. For example, stock checks and list of controlled drug prescribers.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing.
- Arrangements for dispensing medicines kept patients safe.
- Palliative care patients were treated as a priority to receive access to pain relief and other medication required to control their symptoms.

Track record on safety

The service monitored safety, however did not always respond to actions appropriately.

- As mentioned earlier in safety systems and processes, although relevant health and safety risk assessments were carried out, there were inconsistencies in how they were actioned by the provider.
- There was a system for receiving and acting on safety alerts. There were 2 clinical team members responsible for reviewing the alert. This was forwarded to a member of the administrative team to disseminate for team awareness and action.
- Where incidents had occurred, the service fed back areas of concerns to the NHS111 service and the local A&E department. Where serious incidents (adverse events where the consequences to patients are so significant or learning is so great that a heighten level of response is justified) had occurred the service responded appropriately working with other organisations.

Lessons learned and improvements made

At the last inspection in November 2021, we found the service was not able to demonstrate fully how it learned from and made improvements when things went wrong. At this inspection we found areas of improvement, for example:

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses.
- There was mixed feedback from staff regarding the feedback and support provided by senior leaders when raising incidents. Out of 30 returned staff surveys, 9 felt they could raise concerns, 3 did not feel they could raise concerns, 14 felt they could raise concerns but did not always get feedback, 2 felt they would raise concerns but were concerned about repercussions, 1 gave mixed feedback and 1 did not answer.

Requires Improvement

Are services safe?

- There were systems for reviewing and investigating when things went wrong. The service logged significant events on a system called Datix and these were reviewed. Themes and trends were taken to the service's monthly Quality Assurance meetings, which highlighted main concerns. For example, delays in care and contact, not receiving a response, lone working and prescription problems. We found some trends were acted on, whilst others remained an ongoing concern with no formal action plan. For example: 8 out of 30 staff reported concerns over lone working and there were 6 events raised on Datix by staff between January 2022 and October 2022 regarding concerns over working alone and management of patients. Whilst lone working, staff reported not receiving contact from the central hub, difficulties managing unwell patients. Leaders had recognised this as a risk and placed lone working on their risk register in October 2022. However, we found the actions identified to mitigate the risks associated with lone working had not been adhered to in the weeks prior to inspection.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. Where there had been a serious incident, we saw they had collaborated with other services to identify areas of learning.
- Where learning or improvements were identified about another service, this was fed back.

Requires Improvement

Are services effective?

At the last inspection, we rated the service as requires improvement for providing effective services because there had been a decline in the delivery of effective care and treatment for patients.

At this inspection we have continued to rate the service as requires improvement because:

- There was continued ineffective oversight and management of delays in care.
- Some processes to manage staff training and performance were not effective.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians 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 a variety of guidelines, assessment tools and triage templates including from the National Institute for Health and Care Excellence (NICE), National Early Warning Score (NEWS- which is used to assess patients at risk of sepsis), The British National Formulary (used to guide medication and prescriptions) and used this information to help ensure that people's needs were met. The provider monitored these guidelines were followed.
- Although there were triage templates available, clinical staff were not required to use them. The service assured themselves that clinicians were assessing patients in full by auditing them. The audit tool included checking patient demographics, patient's medical history, discussion of current complaint and safety netting advice.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Staff could access patient records and previous clinical encounters with the out of hours service.
- The service were able to access special notes for repeat callers. Clinicians within the service were unable to update these, so information was sent to the patient's own GP for updating. They could also identify frequent callers to NHS111 via their flagging system. Clinicians were able to access special notes and clinical records where appropriate for patients with specific conditions including palliative care patients.
- All patients were triaged by telephone before being offered a face to face appointment including those passed to them via NHS111. If suitable, a face to face appointment was offered.
- Staff were able to complete video triage with the use of the GoodSam application. (The GoodSam application provides the ability for those calling services to share their location and live video from their mobile device).
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to their Integrated Care Board on their performance against the standards which includes: audits; response times to phone calls; whether telephone and face to face assessments happened within the required timescales; seeking patient feedback and actions taken to improve quality.
- We published our last inspection report in March 2022, so for this inspection we looked at data from June 2022 to September 2022 to provide the opportunity for improvement. Since February 2022 the service had taken on the Clinical Assessment Service (CAS which involves the triage of 111 calls). The service monitored the outcomes of the out of hours and CAS' NQRs separately.
- For the out of hours (OOH) NQR, there were 8 areas out of 24 where the service was consistently outside of the target range for an indicator. Targets are set at 90% to achieve partial compliance and 95% for compliance. At the time of our inspection, the service had achieved as follows:

- Timely call-back to patients on weekdays (emergency calls) had dropped from being compliant to non-compliant at 50% in October 2022.
- Timely call-back to patients on weekends and bank holidays (emergency calls) ranged between 68% to 100% against a 90% target.
- Timely call back to patients on weekends and bank holidays (Urgent calls) ranged from 67% to 87% against a 90% target.
- Timely face to face consultations (patients presenting at Primary Care Centre) within 2 hours ranged from 76% to 85% against a 90% target.
- Timely face to face consultations (home visit) within 2 hours ranged from 55% to 75% against a 90% target.

- For the Clinical Assessment Service NQR, there were 8 areas out of 24 where the service was consistently outside of the target range for an indicator. Targets are set at 90% to achieve partial compliance and 95% for compliance. These included:
  - Timely call-back to patients on weekdays (emergency calls) ranged from 56% to 70%.
  - Timely call-back to patients on weekends and bank holidays (emergency calls) ranged from 49% to 61%.
  - Timely call-back to patients on weekdays (urgent calls) ranged from 61% to 75%.
  - Timely call-back to patients on weekends and bank holidays (Urgent calls) ranged from 59% to 63%.
  - Timely advice to healthcare professionals (including paramedics) ranged from 46% to 62% compliance. We were told in October 2022 where compliance was at 54%.

- We made a comparison in the quality standards data from June 2021 to September 2021 with June 2022 to September 2022. The target percentage is 95%, with compliance starting at 90%. In the dates between June 2022 and September 2022, the service were managing CAS calls and OOH calls. We found some areas of improvements which included:
  - The total number of cases had remained at similar amounts. Between June 2021 and September 2021, the service managed an average of 6,273 cases. Between June 2022 and September 2022, the service managed an average of 6,303 cases.
  - The percentage of calls triaged within 20 minutes (urgent), there had been no significant change between the two years. There was an average of 83% achievement in 2021 compared to an average of 85% in 2022 inclusive of CAS data.
  - The percentage of calls triaged within 60 mins (urgent/routine), we saw there had been an improvement from an average of 46% in 2021 to 77% in 2022. This was still below the 90% target.
  - The percentage of calls triaged within 2 hours (routine), we saw there had been an improvement from an average of 62% in 2021 to 72% in 2022. This was still below the 90% target.
  - The percentage of calls triaged within 6 hours (routine), we saw there had been some improvement from an average of 70% in 2021 to 78% in 2022. This was still below the 90% target.
  - The percentage of urgents consulted within 2 hours, there had been no significant change of an average of 81% in 2021 to 80% in 2022. This was still below the 90% target.
  - For the percentage of urgents visited within 2 hours, there had been a decline with an average of 78% visited within timescale in 2021, compared to 69% in 2022. This remained below the 90% target.
  - For the percentage of routines visited within 6 hours, there had been no significant change in the same time period. There had been an average of 87% met in 2021 compared to 85% met in 2022. This was still below the 90% target.
  - Other quality standards had remained the same and within compliance.

- The same staff were used for both the out of hours and clinical assessment service. Between June 2022 and September 2022, we saw the compliance for the number of unfilled shifts (across all staff groups) was between 22% and 27% with the exception of July 2022 where there was compliance of 43%. This was outside of the key performance indictor acceptable range.

Requires Improvement

Are services effective?

- The service monitored this data and provided context to the percentages. They told us they were due to implement a new rota that had been generated based on previous years demand. They told us this would allow them to rota staff where it was most appropriate. They had begun discussions of this in May 2022, however it was not yet implemented. There were some discrepancies regarding the projected implementation date.
- Senior leaders told us they managed clinical oversight of the queue through patient safety callers and asking clinicians to monitor the queue. We were not assured this was effective.
- The service had been implementing the use of patient safety callers since the last inspection in November 2021. Patient safety callers were non-clinical staff members who rang patients who had not received a clinical call within the target time. They were expected to apologise for the delay and check if the patient condition had changed. This had been rolled out at provider level as a central hub, with local staff being trained. We saw evidence training had begun and audits were being carried out in line with the local operating procedures. However, there were some inconsistencies found amongst staff carrying out this role and the training they had received. At a local level, staff were expected to complete this role alongside their primary role, for example, receptionists and drivers.
- We saw evidence where clinicians had not responded to patient safety caller requests to prioritise a patient, while some clinical staff we spoke to did not feel comfortable accessing calls without actioning it, due to fear of retribution should an incident occur.
- The service meets with the commissioner and submits data regarding National Quality requirements monthly. The data submitted was in line with the reports submitted nationally under this provider. We were told key performance indicators and data presented locally had not been agreed with the commissioner.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. We saw that clinical triage audits were carried out on a monthly basis.
- The service completed a variety of audits which included a controlled drug audits, IPC audits, clinical consultation audits, safeguarding audits and governance audits. The service held an audit schedule which was completed on a monthly basis. These had been completed, however it was not clear what actions were when compliance was not at 100% and how this was used to drive improvement.
- The clinical audits were fed back to individual clinicians and where performance was variable, an explanation was given to the clinician to review. We were told, if a trend of poor performance developed, the clinician would be invited for a performance review. We saw some evidence where staff had challenged or wished to discuss their results further, however it was not routinely fed back in a face to face environment, unless there were concerns over performance. We were not assured during the inspection as to how clinical audits were used to drive improvement for the service.
- The service was actively involved in quality improvement activity, by reviewing similar actions at provider level. For example,
  - Following a pilot, the service had introduced the use of video consultation to improve clinical decision making.
  - The service had been liaising with Healthwatch (an independent statutory body who support patient voices and improving standards of care) on how they review complaints, to improve their responses.
  - The service had introduced recording of telephone consultations on mobile phones, so all conversations could be used in reflections and investigations.
  - The service was reviewing the rota with the vision of introducing a “Smart Rota” which looks at how best to fill rota based on previous clinical demand. This had not been implemented at time of inspection.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles, however oversight of training and governance required improvement.

Requires Improvement

Are services effective?

- All staff held appropriate qualifications, however there were inconsistencies in the documentation of staff inductions. During the inspection, we reviewed 12 recruitment folders, of which 7 had started employment in the last 12 months. Out of the 7 new starters, 1 staff member had a completed induction checklist, 3 had evidence to say they attended a presentation, 2 had evidence of shadow shift dates and 2 had no evidence of induction. A formal induction process was due to be introduced for operational staff but this was not yet implemented.
- Post-inspection we were sent evidence that staff received a presentation and minimum of 3 shadow shifts. Staff were then required to sign a form to confirm they had received an induction. We were also sent evidence that clinical staff are required to have a form to evidence they had completed an induction filled out prior to starting shifts. This checklist included all Human Resources (HR) documents sent in, IT systems set up, and introduction complete. This was not embedded into staff files. The service did not assess competence of staff during the induction phase but were audited in line with all staff.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. Leaders audited staff at random on a monthly basis to ensure they were working to the expected standard. There was a medical (Doctor) on call available if required.
- Contracted staff and self-employed staff were not required to complete the same level of mandatory training. For contracted employees, where mandatory training could not be completed in work time, staff were paid this as overtime. Self-employed medical staff were not required to evidence they had completed training for equality and diversity or Mental Capacity Act as part of their mandatory learning in line with guidance. There were inconsistencies in monitoring of learning needs of staff.
- The provider did not have accurate oversight of staff mandatory training. During the inspection, we reviewed training matrixes for contracted and self-employed staff. The matrix for self-employed clinicians showed, out of a total of 87 clinicians, 65 did not have valid basic life support training, 23 did not have valid infection prevention and control training, 22 did not have valid safeguarding children training and 12 did not have valid adult safeguarding training. We were provided with evidence which showed this had been noted during quality assurance meetings and certificates were due to be added. However, at the time of inspection, there had been no action to update the records to accurately reflect current training standards. Following the inspection, we were provided with an updated training matrix for the same group of employees, which showed out of 76, 6 were outstanding basic life support training, 23 were out of date for child safeguarding, 8 were out of date for adult safeguarding, 18 were out of date for information governance, 27 were out of date for infection prevention and control and 3 were out of date for prevent training. 11 self-employed staff had been removed from the matrix as they had not completed any work for the service in 6 months and therefore would not be able to complete a shift. For contracted staff we found that for 85% of staff had valid equality and diversity training, 86% of staff had valid fire awareness training, 91% of staff had valid basic life support training. Out of 14 clinical contracted staff, 1 did not have valid safeguarding training.
- The service told us they had introduced a 4-stage process to improve staff uptake of mandatory training. We could not be assured this would be effectively implemented as records were not always up to date.
- Qualifications were not routinely held in staff files, however the service reviewed clinical registrations, for example the General Medical Council and Nursing and Midwifery Council on an annual basis to assure themselves that all clinicians had the necessary qualifications to continue practising.
- The service primarily used self-employed clinicians for day to day rota fill. The service told us due legislative implications (HM Revenue and Custom IR35 off-payroll working) they could not routinely offer these staff learning and development opportunities. These staff members were required to submit mandatory training in line with the provider policy, however we found they were not always held to account where this information was not submitted.
- Contracted staff told us that the provider had started to offer more opportunities to learn, develop and understand other roles within the service. For example, reception staff were being offered the opportunity to shadow the coordinator role and some drivers had been trained in the reception role.

Requires Improvement

Are services effective?

- There was an inconsistent approach to management of appraisals. During the inspection, we received 30 completed CQC questionnaires from staff. 16 staff members told us they had not received an appraisal in the last 12 months or longer, 7 told us they received an appraisal from another employer, 6 told us they had received an appraisal and one told us they had received an appraisal but felt it was insufficient.
- During the inspection, we were told appraisals had not been completed due to operational demand and leaders had been awaiting training on the new appraisal system. Training had now taken place and staff had been requested to complete the first section of the appraisal online. Post-inspection, we were provided with evidence of appraisals had begun to be booked since the inspection date.
- We saw evidence that one to one meetings had been set up for some operational management. These were not formally recorded or placed in HR files.
- Non-medical prescribers were required to fill in a self-declaration annually to evidence they were still competent to prescribe. The service completed prescribing audits alongside clinical assessment audits. We did not see this embedded into staff files.
- Staff were placed on performance reviews when trends of poor performance arose.

Coordinating care and treatment

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

- Where appropriate, staff liaised with others, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services or when they were referred to hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, safeguarding referrals were carried out where appropriate and staff liaised with specialists where patients had a complex history. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. Staff were unable to update special notes but would add the notes to the patient records to be sent to the GP for updating.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to staff. This could be accessed via two software systems the service used by suitably qualified staff.
- The service ensured an electronic record of all consultations was sent to patients' own GPs. This was monitored in line with key performance indicators.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them.
- Issues with the Directory of Services were resolved in a timely manner.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support and referred patients to appropriate services.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given. Where contact with patients revealed patients were vulnerable or in need of further support, this information was passed to their regular GP along with their consultation notes.

Requires Improvement

Are services effective?

- 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.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. Patients requiring end of life support were given priority and were managed by appropriately qualified staff.
- The service monitored patient feedback. Between November 2021 and October 2022, most patients reported that they felt they were treated with respect and listened to during their consultation.
- We reviewed patient compliments which included that staff were kind, helpful and knowledgeable.

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, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- Where patient needs were complex, staff would source advice from specialists to ensure safe, continuing care for patients.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- 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.
- The service monitored the process for seeking consent appropriately.

Requires Improvement

Are services responsive to people's needs?

At the previous inspection we rated the service as requires improvement for providing responsive services because patients were not always able to access care and treatment from the service within an appropriate timescales for their needs.

At this inspection we rated the service as Requires improvement for providing a responsive service because:

- Systems & processes to ensure adequate management & oversight of access to the service were not always effective.
- Although improvements had been made to the management of complaints, learning from complaints to improve patients experience was not always managed effectively.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population, however these were not always met. Out of the 6 commissioned PCC's, 2 have been closed since the last inspection, 2 have been used on an ad hoc basis and 2 remain open. The commissioner agreed to the closures of bases with the caveat that those staff should be utilised in visiting cars or at other PCCs. We saw that visiting cars were not always available due to difficulties with rota fill.
- The provider routinely provided face to face appointments at Gloucestershire Royal Hospital PCC with Cheltenham General hospital PCC available for face to face appointments until midnight.
- The provider engaged with commissioners, however, it did not always seek support to make meaningful improvements to the local population; for example, increased involvement in the local hospice and profiling on local demand.
- The service had a system in place which alerted staff to any specific safety or clinical needs of a person using the service. The service was able to access "special notes" relating to the patient's health and social circumstances to inform decisions. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises that were open to patients were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. The service told us they were managing 80% calls via telephone triage at the time of inspection. There was a home visiting provision in place. There had been no assessment of outcomes of these patients. For example, where patients had not been offered a face to face assessment, how many had required a face to face assessment from another service.
- The service gained patient feedback through, patient satisfaction questionnaires, healthcare professional feedback (HPF) and the friends and family test. This was reviewed at quality assurance meetings.
- Feedback through HPF had been none to 3 patients a month between February 2022 and September 2022, which was similar to other locations under this provider.
- Feedback through patient satisfaction questionnaires we reviewed from June, August, September and October 2022 showed an average of 67% positive feedback, 26% negative and 7% neutral.
- We looked at NHS Friends and Family Test results between February 2022 and September 2022, which had an average of 68% against a target of 75%. (The NHS Friends and Family Test is to show how likely patients are to recommend their friends and family to use the service).
- The service told us to address themes such as delays, pharmacy issues, signage, they had implemented the following:
  - Introduced patient safety calling, which involved non-clinical staff members calling patients back who were experiencing delays. This had begun to be implemented at the last inspection in November 2021, where we had identified issues.
  - Informed clinicians of an improved process, so patients can get their prescription from any pharmacy.
  - Improved some signage at Gloucestershire Royal Hospital.
  - Begun gaining feedback from staff through meetings.

Requires Improvement

Are services responsive to people's needs?

Timely access to the service

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

- Patients were usually able to access care and treatment at a time to suit them. The service operated from 6.30pm to 8am Mondays to Thursdays and 24 hours from 6.30pm Friday to 8am Monday. The service aimed to consistently have Gloucestershire Royal Hospital PCC open throughout this time with Cheltenham General Hospital PCC open until 11pm and the occasional opening of a 3rd PCC site. There were 2 bases that had been closed for the past 12 months which still appeared on the service's website.
- Patients could access the out of hours service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- Patients were generally seen on an appointment basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases arose. The reception staff had received sepsis training which they used to alert the clinical staff if a patient had an urgent need.
- At the last inspection we reviewed key performance indicator results for the service for the period of November 2020 to September 2021 which found they were meeting the following indicators:
  - The percentage of patients with urgent care needs visited within one hour was 100%, with the exception of one month.
- At the last inspection, we found for the same period the service was not meeting the following indicators:
  - The percentage of patients with urgent care needs visited within two hours ranged from 71% to 95% against a target of 95%. Performance from April 2021 to September 2021 was consistently below 95%.
  - The percentage of patient with routine care needs visited within six hours, ranged from 82% to 96% against a target of 95%. Performance from April 2021 to September 2021 was consistently below 95%.

- For consistency, at this inspection we reviewed the key performance indicator results for April 2022 to September 2022. The minimum target was set to 90%. We found they were meeting the following indicators:
  - The percentage of patients receiving face to face consultation at a PCC within one hour was 100% for April 2022 and September 2022. There was no data for the other months for this indicator.
  - The percentage of patients receiving face to face consultation at a PCC within 6 hours between April 2022 and September 2022 was between 91% and 98%.
  - The percentage of patients receiving face to face consultation at a PCC within 12 hours between April 2022 and September 2022 was between 89% and 100%. The service had been consistently above 95% since June 2022.
  - The percentage of patients receiving face to face home visit within 24 hours was consistently at 100%.

- At this inspection we found the service was not meeting the following indicators:
  - The percentage of patients receiving face to face consultation at a PCC within 2 hours between April 2022 and September 2022 ranged between 76% to 85%
  - The percentage of patients receiving a face to face home visit within 1 hour between April 2022 and September 2022 ranged from 50% to 100% with no data present for July 2022 to September 2022.
  - The percentage of patients receiving face to face home visit within 2 hours between April 2022 and September 2022 ranged between 55% and 76%. The 55% was for the month of September 2022. The service were not meeting this at the last inspection in November 2021.

Requires Improvement

Are services responsive to people's needs?

- The percentage of patients receiving face to face home visit within 6 hours between April 2022 and September 2022 ranged between 75% to 92%. 5 out of the 6 months were below the 90% minimum target.
- The percentage of patients receiving face to face home visit within 12 hours between April 2022 to September 2022 ranged between 50% to 100%. 3 out of the 6 months were below the 90% minimum target.

- The service monitored the areas where targets were not being met, including the amount of consults not being met.
- The service held a risk register to keep oversight of areas of concern. This included awareness of large amount of calls and national clinician shortage which had been risk rated and control measures identified. The service had identified delays as a source of patient complaints and feedback, staff feedback and looked at longest waits to assess clinical impact, but delays was not specifically present on the risk register. We found the risk register did not include the consistent inability to meet certain targets.
- The service employed clinicians on a Monday morning and occasionally on other weekday mornings to assist with triaging the call queue after the service had closed. This was to avoid the calls being passed to in hours GP practices. If the patient required a face to face appointment, they would then be passed to their own GP or another service. The service did not monitor how many of these calls were closed following the patients seeking their own advice or support elsewhere.
- Where there were delays in responding to patients, the provider had employed non-clinical staff known as patient safety callers to cover services nationally inclusive of this one. Locally the service had begun implementing this role amongst existing non-clinical staff for example receptionists, coordinators and drivers, however this was not yet effective. The purpose of this role was to contact patients who were experiencing delays in clinical contact so any deterioration in patient status could be flagged to a clinician. We found processes for the implementation of this was not always effective including inconsistencies in the training provided to staff carrying out this role and evidence of patient safety calling was not always occurring for this service by national staff. We also found evidence of where patient safety callers had escalated concerns for a patient, but had not always been acted on by clinicians.
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services such as the use of language translation services, completing video consultations or providing home visits.
- All calls were triaged by telephone before being offered a face to face appointment.
- When patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The appointment system was easy to use.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaints policy and procedures were in line with national guidance. The service had received 29 complaints in the last year. On review, we found complaints were managed in line with the policy, were responded to and added to the monthly 'Reflects' (a staff newsletter) that get sent to staff where appropriate.
- The service was inconsistent at using individual complaints and concerns to improve service delivery. We saw lessons were learnt, and actions taken in relation to complaints involved speaking with staff to highlight individual errors and a reminder of policy or processes. Complaints and themes, such as delays, were added to the monthly "Reflects" which were sent to staff where leaders deemed it was appropriate. This information was used as reminders for staff and was not used to disseminate how the service could improve. Some complaints disseminated were still under investigation, therefore there was no learning attached.
- The service had begun liaising with an Healthwatch (an independent statutory body who support patient voices and improving standards of care) on how they review complaints.

Requires Improvement

Are services well-led?

At the previous inspection in November 2021, we rated the service as requires improvement for providing well led services because:

- Concerns highlighted during the inspection in August 2019 were still present.
- These included, high turnover of middle management which had led to a lack of oversight in governance and staff reporting lack of visibility and support from management.

During this inspection, we have continued to rate the service as Requires improvement for providing well led services because:

- Despite action being taken to improve the visibility of management, further improvement was required to improve the culture of the service.
- There continued to be a lack of oversight in governance including implementation and monitoring of processes and responding to actions from risk assessments.
- There were inconsistencies in the effective monitoring of staff competency including monitoring of mandatory training, effective inductions and staff appraisals.
- The service did not always respond to service delivery concerns when highlighted through key performance indicators for service delivery or complaints.
- The service did not provide a vision or strategy to ensure they were in line with their values.

Leadership capacity and capability

The capacity of leaders had increased since the last inspection but we were still not assured about their ability to deliver high-quality sustainable care. Some staff continued to feel leaders were not open and transparent.

- Since the last inspection, there had been changes in middle management, which included the recruitment of a new service manager and an out of hours manager in June 2022, who told us they were still embedding into their roles at the time of inspection.
- The service had increased the hours of some key managers with the vision of improving clinical oversight and clinical management.
- We were told managers had spent time with staff in the out of hours setting to improve communication and visibility.
- Staff gave us mixed feedback regarding leaders. Out of the 30 returned staff surveys where we asked if staff felt leaders were open and transparent, 21 answered no, 5 answered yes and 4 gave mixed feedback. Themes of the answers included a lack of communication, a lack of support and not feeling leaders were engaged with their staff. Staff who answered positively told us they felt supported by their immediate line manager.
- The service had adopted some quality improvement by reviewing similar actions at other locations by this provider. Since the last inspection, this had included the introduction of GoodSam (a programme to complete video consultation), mobile telephone consultation recording via the Avaya app and working with Healthwatch to review patient complaints. Work had started on reviewing rota improvements, but this was not yet implemented.

Vision and strategy

The service had clear values which staff were aware of but the strategy to deliver those values effectively was not in place.

- The service had clear values and staff we spoke to were aware of and understood their role in embedding this.
- Senior leaders presented their main challenges during the inspection and how they planned to improve these. However, it was not clear how they were going to ensure any changes were going to be effective and in line with their values.

Requires Improvement

Are services well-led?

- The challenges presented were reflective of some of the issues we found during the onsite inspection, however further issues found had gone unrecognised by senior leaders for example gaps in recruitment and staff training.
- The service did not provide a strategy or any supporting business plan to ensure the values were upheld.

Culture

The culture of the service did not effectively support high-quality sustainable care.

- There was a whistleblowing policy in place and most staff knew how to access this. It included contacts to raise concerns to including, internal but not local staff at director level, external organisations and regulator details.
- Most staff felt they could raise concerns but they weren't always listened to effectively. Staff who felt like they couldn't raise concerns told us it was because they feared they would lose their job.
- Some staff told us communication had improved since the last inspection. We saw evidence to demonstrate team meetings had started and monthly newsletters were being disseminated. However, not all staff felt this method of communication was effective. We raised this with senior leaders on the day of inspection, who recognised the ongoing challenges with staff engagement, however there were no actions to further improve this.
- The service provided monetary rewards for staff who had been nominated by colleagues. Staff who were nominated would also be entered into a national prize draw.
- Staff were supported to meet the requirements of professional revalidation where required, however, there were not effective processes for providing all staff with the development they needed. Appraisals had not been completed whilst a new system was being implemented. Some staff reported they had not received an appraisal for many years or if they had received one, it was not carried out effectively. Appraisals were not embedded into staff files.
- The majority of staff were self-employed and not contracted directly by the service. Staff who were contracted by the provider were supported to complete mandatory training. If they could not complete this during working hours, they could claim it as overtime. We were told self-employed staff could not be routinely be offered training but were given access to the training platform used by the service.
- Feedback from staff surveys indicated most staff felt their views were not listened to or acted upon. Other feedback included getting views listened to and actioned would depend which part of the service the view was on. Senior leaders told us they had worked on being more open and responsive to staff. They told us all concerns could be raised via Datix, email or to an email open suggestion box. None of these options were anonymous.
- Leaders and managers had begun to act on behaviour and performance inconsistent with their values. We saw an example of a staff member who had been placed on a performance review.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Apologies to patients were made in most cases. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- The service did not require self-employed staff to provide equality and diversity training certificates. We received mixed feedback regarding fair treatment of staff. Some staff felt preferential treatment was given to certain individuals or staff groups. Incentivised shifts had caused some staff groups to feel undervalued and could have a negative effect of overall rota management.

Governance arrangements

Governance arrangements were not always operated effectively and were not always successfully implemented at a local level. Most leaders had clear responsibilities, but due to staffing issues, responsibilities had shifted and were sometimes unclear at the middle management level.

Requires Improvement

Are services well-led?

- The service held an organisational chart. Due to various reasons including staff sickness and staff leaving the service, line management and responsibilities had changed for some staff. Staff with key responsibilities such as safeguarding were aware of their role, however over 50% of those who returned staff surveys could not correctly identify the safeguarding lead. Clinicians managed safeguarding issues following escalation procedures appropriately.
- Structures, processes and systems to support good governance and management were clearly set out, but not always effective. For example:
  - Key performance indicators were monitored, but where they were not met, changes or actions had not always been developed to implement improvements to the service.
  - There were processes to monitor staff training through quality assurances meetings, however the service did not respond or action their findings to assure themselves that information was up to date.

- Risks to staff including management of staff immunisations were not managed in line with guidance. For example, non-clinical staff that handled sharps boxes or would be required to provide basic life support had not had their immunisation status checked to reduce the risk of harm.
- Since the last inspection, there had been some improvement made to the way the service responded to significant events and complaints. However, further improvements were required to ensure the learning from these were used for developing the service.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Where the provider had introduced a national policy or procedure, these were not always effectively implemented. For example, staff identified as lone working were not always treated in line with the lone working policy and the implementation of patient safety callers had not been successful at a local level.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not always effective.

- The service held a risk register to monitor service risks, however the risks were not always effectively managed or monitored. For example, the service acknowledged demand can be difficult to manage. It was not clear how the control measures would be implemented. Service performance was not on the risk register.
- Health and safety risk assessments and audits were carried out to keep patients safe. We saw some evidence of actions which had been left outstanding, with no rationale as to why these has not been implemented. However, actions had begun to be implemented at the time of inspection. We found despite medicines audits occurring, an incident was raised during the inspection due to the service not realising they had not received an emergency medicine from the supplier.
- Senior leaders monitored staff performance through audits. Clinical staff received feedback including comments on where improvements could be made. Leaders had oversight of MHRA alerts and providing evidence of disseminating information.
- The performance of the service was discussed regularly at monthly Quality Assurance meetings. Staff members had been invited to join this meeting and data was shared with the commissioner.
- Although the performance of the service was discussed at these meetings, it was not clear how the information was used to improve the service. For example, we saw leaders had discussed training data which indicated staff were not up to date for mandatory training. It was highlighted that they felt it was likely to be a result of not uploading certificates in September and October 2022, however this was not actioned by the time of our inspection in November 2022.

Requires Improvement

Are services well-led?

- The service had improved their processes for reviewing significant events and complaints. All significant events and complaints were recorded on the Datix system and were reviewed by senior leaders. Some information was disseminated to staff, however we found this was not always effective. Information shared including learning or reminders for staff, however incidents shared were at times selective or shared whilst it was still in process. It was not always clear what actions the leaders or service intended to take to make improvements.
- The service had failed to act on an issue raised at the previous inspection. For example,
  - Ensuring sufficient staff numbers to maintain a safe and effective service.
  - Ensuring learning from incidents, complaints and data was effectively actioned.
  - Completing annual staff appraisals.

Appropriate and accurate information

The service acted on appropriate and accurate information; however, it was not always effective.

- Patient safety calling was implemented at the last inspection in November 2021. At this inspection in November 2022, this had not yet been effectively embedded. We were told a group of staff had just completed training so would now be able to undertake this role. We spoke to some staff who had continued with this despite not receiving training.
- Patient safety callers that had completed the training had been audited to ensure they were in line with the local operating procedures.
- Following the inspection, the service sent us evidence that they audited failed encounters. However, it was not clear if this was an audit for this location and where it had been found that processes had not been followed. It was also not clear what actions were going to be taken to improve the service.
- Audits and performance information was reviewed by senior leaders, however it was not always clear how this information was updated or reviewed to ensure its accuracy.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate however, it was not clear how this information was used to drive improvements.
- The service submitted data or notifications to external organisations as required.
- 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

The service engaged with patients, the public, staff and external partners, but it was not clear how the information collected was used to support high-quality sustainable services.

- The service had regular meetings with the commissioners about service performance.
- Since the last inspection, regular operational management meetings had started and leaders had carried out a survey to identify when to hold staff meetings. Staff were invited to quality assurance meetings and meetings had changed to times to suit the outcome of the survey. Staff reported mixed feedback to us about the quality and frequency of meetings. Most staff agreed there had been an improvement to the frequency of meetings, however some told us they didn't attend due to clashes with other roles or not being paid to attend. Staff were discouraged from joining meetings during their shifts. The newly implemented meeting, aimed at all staff, needed further embedding and improvements made to ensure staff were given the opportunity to be heard, information to be shared with those not in attendance and consistency for staff.
- Staff were able to feedback to leaders via direct emails, an email suggestion box, team meetings and Datix. Some staff reported they no longer gave feedback due to not receiving an effective response.

Requires Improvement

Are services well-led?

- Patients were encouraged to give feedback via surveys and submission of compliments and complaints. Results of surveys and feedback were discussed at quality assurance meetings and disseminated to staff via email. It was not always clear how this information was used to drive improvement.

Continuous improvement and innovation

At the last inspection, the service could not provide evidence of any processes for learning, continuous improvement and innovation. At this inspection, we found some systems and processes had been implemented, but required further embedding.

There were some systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement for staff within the service. Individuals were audited and fed back to for learning. However, it was not always implemented at service level; for example, the service had assessed themes of complaints and feedback included delays to care or not being contacted. For delays, the service had identified a new rota could help improve this, however there had been no further implementation of this since May 2022, and patient safety callers had not been successfully implemented.
- Staff receiving feedback acknowledged when improvements could be made.
- Since the last inspection the service had made improvements to the handling of complaints. It had sought assistance from Healthwatch England where appropriate, and had piloted a 24 hours clinical assessment service. The clinical assessment service 24 hour pilot was not continued.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not always hold records or request immunisation history from staff in line with The Green Book national guidance for immunisation of healthcare staff. This was in breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Training needs for staff required reviewing for a consistent, effective approach to patient safety. For example, chaperone training, equality and diversity training, basic life support and Infection prevention and control. • The service could not evidence staff were effectively inducted into their roles. • There was an inconsistent, ineffective approach to staff appraisals. • Inconsistent and insufficient number of staff to ensure safe care for patients. This was in breach of Regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Since September 2018 there has been a continuation of persistent and consecutive breaches to Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 demonstrating there is insufficient mechanisms in place to demonstrates improvements to leadership and governance is sustainable which puts staff and patients at risk of harm. For example: • Systems to support the safe transport of controlled medicines were not always effective or in line with guidance. • Systems to support medicines management were not always effective. • There was not effective systems in place to support lone workers and identify potential risk. • Systems to disseminate and embed relevant learning following complaints was not effective. • Systems and processes to learn from significant events were not embedded. • There was not effective oversight of staff training to ensure information remained up to date. • Oversight of patient safety had not been effectively implemented or monitored at local level. This was in breach of Regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.