Ashgate Manor

Inspection report

Ashgate Road
Chesterfield
S40 4AA
Tel:

Date of inspection visit: 15-17 October 2023
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Overall summary

This service is rated as Outstanding overall. (Previous inspection, 10 November 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? – Outstanding

We carried out an announced comprehensive inspection at Ashgate Manor between 15-17 October 2023. We inspected this service due to the length of time since our previous inspection, in line with the Care Quality Commission's inspection priorities.

At this inspection we found:

- The leadership, governance and culture within the service drove improvements to deliver high-quality person-centred care. This included collaborative partnerships, multidisciplinary and multiagency working which supported vulnerable patients and tackled health inequalities. The provider was able to demonstrate the positive impact this had on health outcomes for under-represented populations such as homeless people.
- The provider had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the provider learned from them and improved their processes.
- There was a comprehensive and effective system to safeguard children and vulnerable adults. The provider worked proactively and collaboratively with other providers and external agencies to ensure patients were safe.
- The provider routinely and proactively reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment were delivered according to evidence-based guidelines and demonstrated this via a scheduled programme of rolling audits.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on the quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- Feedback from people who used the service, those who were close to them, and stakeholders, was continually positive about the way staff treated people. People thought that staff went the extra mile and their care and support exceeded their expectations. The provider proactively canvassed patient feedback and used this to adapt how services were delivered to enhance experience. We observed staff treated patients with compassion, kindness, dignity and respect during our inspection.
- Patients were able to access out-of-hours care when they needed it at an accessible location, or in their own home when this was appropriate. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- Leaders strove to deliver and motivate staff to succeed. Staff feedback was highly positive about their experience in working for the organisation and staff felt well-supported and were given opportunities to develop.
- The provider supported staff welfare initiatives. There was a wide and well utilised range of schemes and services to promote and support staff physical and mental health wellbeing. This included access to occupational health, counselling and access to an independent health scheme.

Overall summary

- Leaders promoted organisational values which we found were embedded into all aspects of how the organisation worked.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- Leaders embraced innovations and proactively sought out and embedded new ways of working to provide care and treatment. We saw many examples of innovation and the development of services in response to patients' needs. New evidence-based techniques and technologies were used to support the delivery of high-quality care. We saw how innovations had both positively impacted on the care of individual patients, and the wider health and social care system.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser, a nurse specialist adviser, a CQC pharmacist, and a second CQC inspector. There were also 2 observers accompanying the inspection team, these were a second GP specialist advisor and a CQC regulatory co-ordinator.

Background to Ashgate Manor

DHU Healthcare Community Interest Company (CIC) deliver a diverse range of services to the population across several counties including Derbyshire, Leicestershire, Nottinghamshire, Northamptonshire, Staffordshire and the West Midlands.

These services include urgent and emergency care, primary care, out of hours services (including community nursing services), and the NHS 111 service. The types of service provided in each county differs, for example, DHU CIC provide NHS 111 services across the East and West Midlands, and urgent care services across Derbyshire, Leicestershire and Northamptonshire. DHU was formed in 2006 following a merger of Derbyshire Medical Services and Derbyshire Healthcare.

DHU Healthcare CIC is a 'not-for-profit' community interest company, which employs more than 2,000 people in total. The organisation has several registrations with the CQC, but this inspection was focused upon the out-of-hours provision in North Derbyshire delivered by Ashgate Manor. DHU Healthcare CIC is registered with CQC as the provider of out-of-hours services across North Derbyshire to provide the regulated activities of transport services, triage and medical advice provided remotely, and treatment of disease, disorder or injury,

Ashgate Manor is the registered location with the Care Quality Commission (CQC) to deliver out-of-hours services to North Derbyshire. The city of Derby and southern Derbyshire out-of-hours service is also provided by DHU as part of a separate CQC registration.

The out-of-hours service is commissioned by NHS Derby and Derbyshire Integrated Care Board (ICB)/Joined Up Care Derbyshire.

The base is located at:

Ashgate Manor

Ashgate Road

Chesterfield, Derbyshire

S40 4AA

Patients who ring the NHS 111 service out-of-hours have their medical needs assessed by a call advisor or a clinical advisor based on the symptoms they report when they call. If a patient needs to be seen face-to-face by a clinician, appointments are booked directly into the most convenient GP out-of-hours site at one of 8 primary care centres across North Derbyshire; home visits are also provided where appropriate following triage. The out-of-hours primary care sites are:

Chesterfield: Ashgate Manor, Ashgate Rd, Chesterfield, S40 4AA. Open 6pm to 8am Monday-Friday, 24 hours at the weekend.

Buxton: Buxton Hospital, London Road, Buxton, SK17 9NJ. Open 6.30pm to midnight Monday-Friday, 8am to midnight at the weekend.

Clay Cross: Clay Cross Hospital, Market Street, S45 9NZ. Open 9am to 5pm at weekends.

New Mills: New Mills Health Centre, Hyde Bank Rd, High Peak, SK22 4BP. Open 6pm to 10.30pm Monday-Friday, 9am to 10.30pm at weekends.

Ashbourne: St Oswald's Hospital, Clifton Rd, Ashbourne, DE6 1DR. Open 8am to 4pm at weekends.

Bolsover: Castle Street Medical Centre, Castle Street, Bolsover, S44 6PP. Open 9am to 5pm Sunday.

Matlock: Whitworth Hospital, 330 Bakewell Rd, Matlock, DE4 2JD. This site was not operational at the time of our inspection apart from offering some remote advice.

Between 1 October 2022 to 30 September 2023, just over 34,000 patients accessed care at one of these sites. We were unable to obtain figures for contacts where advice was provided (without the need for a face-to-face consultation) and home visits solely for the north of Derbyshire; however combined with the service provided in the south of the county, there were almost 143,500 patients consulted with advice, and just below 22,800 home visits, over the same 12-month period.

This CQC registration also incorporates:

The **evening and night community nursing service**, which DHU subcontract from the local community Trust, who provide the daytime service. DHU have 9 teams delivering this service across the whole county from 6pm to midnight, with 2 teams covering the service from midnight to 8am, operating 7 days a week.

Chesterfield Royal Hospital: (a pilot primary care streaming service co-located with urgent treatment centre) - Chesterfield Royal Hospital, S44 5BL. Open 8am to 11pm, 7 days. The streaming service is an initial triage at the front door to direct patients to the correct area of the department, dependent on the most appropriate pathway of care.

The 111 service is co-located at Ashgate Manor as part of an integrated and streamlined NHS 111 and out-of-hours service. The 111 service operates from the second floor whilst patients access the out-of-hours service on the ground floor. The NHS 111 service was not part of our inspection as this is a separate CQC registration. The 111 service was last inspected in 2019 and the report can be accessed via this link https://www.cqc.org.uk/location/1-2946395439

During the inspection in October 2023, we visited Ashgate Manor, Chesterfield Royal Hospital, Clay Cross Hospital, Buxton Hospital and New Mills Health Centre.

At the time of our inspection, DHU employed over 400 staff in their out-of-hours service across the whole of Derbyshire including 111 advanced practitioners, 24 clinical practitioners 14 salaried GPs,142 health care assistants or combined reception/health care assistant roles and 60 drivers. Locum staff also supported the service.

Good

Are services safe?

We rated the service as good for providing safe services.

Safety systems and processes.

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

- The provider had highly effective systems to safeguard children and vulnerable adults from abuse. Safeguarding policies were regularly reviewed and updated and were accessible to all staff; these outlined clearly who to go to for further guidance. There were named safeguarding leads for both vulnerable adults and children who promoted their role across the organisation, for example, they were about to embark on site visits across the organisation to meet and talk with staff. Clinicians were able to refer any safeguarding concerns directly to the appropriate local authority from the clinical system used for patient consultations, making this a fully electronic process. There was also a process to send early-help notifications for children (support aimed at improving outcomes for children or preventing escalating need or risk) to health visitors and school nurses, and also for care concerns for adults requiring support with activities for daily living. We saw that high numbers of safeguarding referrals were made. From September 2022 to August 2023, 153 safeguarding referrals were made by the provider across Derbyshire. The safeguarding team reviewed all referrals and followed up each case. This included resolving any issues such as misdirected referrals to the wrong local authority. The DHU safeguarding team monitored themes and communicated any relevant issues back to the clinician, for example, if the safeguarding referral was not required, or any learning that might be identified. To support clinicians, the safeguarding leads had developed resources on the provider's intranet page, and this included factsheets to guide staff and locums on particular safeguarding queries and presentations. Examples we reviewed included medications errors in social care, bruising or injury in non-mobile babies or children, and female genital mutilation (FGM). We saw these guides were concise and contained all appropriate key information so that advice could be accessed quickly by any clinician with concerns.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff confirmed that they had received safeguarding training and were able to name the safeguarding leads. Staff also told us as part of our staff questionnaire that they knew how to access safeguarding policies on the provider's intranet.
- The service always operated with a minimum of 2 staff, including for a home visit, or when working at one of the more rural bases. This meant that a chaperone was available if needed. We identified that there was not always easy access to a female chaperone at the Buxton site during the week, and the provider informed us they would review this.
- The provider ensured that safety risk assessments and audits were in place for the premises they used. This included health and safety, fire, and Legionella (a bacteria found in water) risk assessments undertaken by different organisations, such as the landlords of properties they used to provide the service, or expert contractors. These were completed on at least an annual basis. The provider's managers reviewed the findings from audits and risk assessments and regularly liaised with others to ensure that they were actively involved to ensure any identified issues were completed in a timely manner. The provider had a range of safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training.
- There was an effective system to manage infection prevention and control. There were systems for safely managing healthcare waste. There was a named infection prevention and control lead, and plans were being developed to have named infection control links across the various sites. We saw that a schedule of infection prevention and control audits was in place across all premises used for clinical sessions by the provider, and it was planned that the link

network would instigate monthly self-assessment audits with in-built processes for oversight and validation. Action plans were developed from infection prevention and control audits to address any identified shortfalls in standards. All the sites we visited as part of our inspection were seen to be clean and free of clutter. Patient surveys also supported positive feedback from patients regarding the cleanliness of the sites they attended.

- The provider carried out safe employment checks at the time of recruitment and on an ongoing basis where appropriate. This included confirmation of professional registration, previous employment history and evidence of satisfactory conduct in previous employment, immunisation status, DBS and identity checks, and right-to-work confirmation where appropriate. We reviewed how the provider's human resources team collated this information and we saw that there was a structured process to ensure that a full history of recruitment checks was completed prior to the individual commencing their employment. The same assurances were obtained for all agency/locum staff used by the service.
- 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.

Risks to patients.

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

- There were highly effective arrangements for planning and monitoring the number and mix of staff needed. Rotas were planned in advance by a dedicated team, and meetings took place twice daily to discuss and allocate workload by reviewing any gaps in clinical sessions with actions being taken to ensure these were filled, such as using agency staff. On rare occasions, when no cover could be sought, actions were taken to divert activity. There was an effective system in place for dealing with surges in demand.
- Every out-of-hours shift included a named clinical lead (either a GP or advanced nurse practitioner) on duty who would monitor and manage the service county wide. This was also supported by the Urgent and Emergency Care (UEC) coordinator providing operational support. The clinical lead monitored the performance of individuals, the performance within the Primary Care Centres (PCCs), the home visiting service and the Integrated Urgent Care advice queue. They were also available to take calls directly from staff and clinicians who might need clinical support or from the UEC coordinator who may have taken a call from a member of staff calling in sick affecting the team at a site/service. As an extra layer of management and monitoring, a duty manager rota was shared between the UEC clinical and operational managers. They adapted to support and resolve situations that the coordinator or clinical lead needed support with. The duty manager also had the ability to spend more time to support in matters that the coordinator and clinical lead was not able to. We spoke with clinicians who told us this worked extremely well, and that they were able to get a prompt response to resolve any issues.
- There was an effective induction system for temporary staff tailored to their role.
- The out-of-hours usage of locum/agency staff was low. In the last 5 months usage had varied from 2.8% in July 2023 to 5.3% in June. This was low in comparison to similar services and demonstrated effective staffing processes and a stable workforce. Figures showed an improvement from the preceding 6 months when averages ranged from 4.2% to 7.9%.
- Patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage patients who experienced long waits or who had been inappropriately streamed into the service. The shift clinical lead observed the list of patients waiting to be seen face-to-face and ensured that children under 12 weeks of age, pregnant women, or patients experiencing difficulties with mental health, were directed to see a GP rather than an advanced practitioner.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- Sepsis software prompts were inbuilt on the clinical system. This was further supported by 'red flag' training for reception staff. All new clinicians were checked for having completed sepsis training at induction.

Good

Are services safe?

- Monthly meetings took place to discuss the provider's approach to sepsis. This looked at the number of cases seen by staff and the identification of learning opportunities, as well as training, audit, and communicating key messages to the wider team.
- Staff told patients when to seek further help, and they advised patients what to do if their condition got worse. If home visits were delayed, patients were contacted to check on their welfare and to advise what they should do in terms of any significant worsening of their presenting symptoms.

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. 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. For example, to ensure continuity of care a post -event electronic message was sent to the patient's GP detailing a summary of their contact with the out of hours service. In some cases, administrative staff would telephone the practice the morning after attending the out of hours service to share any important information.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines.

The service had reliable systems for appropriate and safe handling of medicines.

- The storage and monitoring arrangements for managing medicines, including medical gases, emergency medicines and equipment, controlled drugs, and vaccines were seen to be safe. We inspected 2 cars used as part of the home visiting service and found that effective arrangements were in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- 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. There was evidence of actions taken to support good antimicrobial stewardship.
- Staff had the appropriate authorisations to administer medicines including the use of Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) when appropriate. We saw signed examples of PGDs during the inspection. Quarterly audits of PGDs were undertaken to ensure ongoing compliance with legal requirements.
- Processes were in place for checking medicines stored on site and staff kept accurate records of medicines.
- There were appropriate systems to manage controlled drugs on the premises and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, were in line with national guidance. There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.
- Arrangements for dispensing medicines kept patients safe. Any medicines dispensed from a location or during a home visit were recorded and a lilac prescription (FP10P – REC) was generated to identify any replacement stock required.
- Palliative care patients were treated as a priority to receive prompt access to pain relief and other medicines required to control their symptoms.
- The majority of prescriptions generated for patients were completed electronically (approximately 80%), but we saw that paper prescription stationery was secured and its use was closely monitored with records maintained to evidence this.

Good

Are services safe?

- We saw that fridges used to store medicines had maximum and minimum temperatures were recorded on a daily basis. Records demonstrated fridge temperatures were being maintained in line with guidance. A data logger was also kept in fridges and periodically downloaded or when there had been a temperature breach.
- A separate fridge was seen at Ashgate Manor to store antiviral medicines used to treat COVID-19. This was located in a room next to a rear entrance of the property so that COVID positive patients, referred by their GP or the hospital, could go directly to the designated clinic room avoiding contact with staff (other than the staff member administering the treatment) and patients. The provider had agreed to deliver this service to help keep people away from the hospital environment.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed information from a range of sources including incidents, complaints, patient/staff feedback and audits. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts. We saw that logs were maintained for reference and any relevant alerts included information of the response undertaken. The service had an effective mechanism in place to disseminate alerts to all appropriate members of the team including sessional and agency staff, and we saw examples to support this. A list of alerts including any follow-up actions was reported to the quarterly Clinical Quality Review Group meeting.

Lessons learned and improvements made.

The service learned and made improvements when things went wrong.

- There was an embedded process and system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- We were provided with evidence of incidents reported over the last 12 months. There had been 219 incidents reported across the service. These had all been logged detailing what had happened, the level of risk, details of any investigation and the actions taken, and the learning to be applied and shared from the event.
- There were effective systems for reviewing and investigating when things went wrong. All clinical incidents were reviewed at the clinical quality risk group. The service learned and shared lessons, identified themes and took action to improve safety in the service. Staff were able to provide examples of learning from incidents. For example, a patient had been experiencing unusual or minimal symptoms of a silent myocardial infarction (a heart attack with only mild or no symptoms) which were not identified during a consultation. This led to the NHS pathways software being adapted, and learning was shared with clinicians through a newsletter.
- The provider had undertaken a review of patient safety incidents from several sources reported between July 2020 and January 2023 to identify learning themes. The incidents were categorised and ranked by means of numbers and potential level of harm, resulting in the identification of a top 10 patient safety types. Following internal consultation and with stakeholders, a patient safety incident response plan was produced which outlined the recommended responses to be taken and plans for further improvement. It also referenced how patients, families and staff would be involved in following up a significant patient safety incident. We saw that the provider adhered to their duty of candour.
- An audit was undertaken to ensure any changes, required to processes resulting from any particular incident, had been implemented.

Good

Are services safe?

- The service shared the outcomes of significant events with their commissioner, the Integrated Care Board (ICB).

Outstanding ☆

Are services effective?

We rated the service as outstanding for providing effective services. This was because:

- The out-of-hours service had a track record of meeting and exceeding targets and key performance indicators. Their performance was sustained and consistent even during periods of extreme urgent care system pressure.
- We observed a fully embedded regular programme of audit that continually drove high standards. This included a comprehensive programme to continually review clinical consultations and prescribing for all staff, including locums, to maximise patient safety and enhance clinical performance.
- Effective systems ensured that staff and locums were appropriately trained and updated in line with the provider's mandatory training programme. Staff at all levels were provided with opportunities for development. We saw many examples of how learning was shared across the organisation.
- Staff appraisals were linked to organisational values, and included questions to determine what factors were important for staff retention, and to assess the impact of the 'Inspire' training programme for managers (Inspire was an externally facilitated management development programme).
- The service promoted confidential 'safe space' clinical supervision in addition to its usual operational and clinical governance processes. We saw there was a good uptake of supervision.
- We saw examples of successful quality improvement programmes including a project which had significantly reduced the number of contacts with high-frequency and high-impact users.

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 guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that patients' needs were met. The provider monitored that these guidelines were followed. A monthly clinical newsletter was produced which included details and links to new and updated NICE guidance. Some of the NICE guidance was explained in full within the newsletter, and we saw recent examples pertaining to hypertension in adults, diagnosis and initial management of ectopic pregnancy and miscarriage, and head injury. The newsletter contained other information for clinical staff, for example, we saw information on sepsis, and the assessment and management of chronic pain. Actions pertaining to NICE guidance were reviewed on a bi-monthly basis at the Clinical Quality & Patient Safety Sub-Committee for assurance.
- The provider used other assessment tools, for example, the National Early Warning Score (NEWS) which improves the detection and response to clinical deterioration in adult patients.
- The service had developed its own out-of-hours medicine's formulary (a list of medicines approved for use within the service) to help ensure the safe and effective use of medicines. This was important as a reference as many clinicians worked in different settings and needed to ensure that their prescribing when working for the out-of-hours service was in accordance with the formulary.
- All patients passed for a clinical review were triaged by telephone before being offered a face-to-face appointment.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- 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 NQRs are used to show the service is safe, clinically effective and

responsive. These had been superceded recently by the Integrated Care Service Specification, although the principles of the NQRs still applied. The providers reported monthly to their Integrated Care Board (ICB) on their performance against the standards which included: 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.

- The service met and mostly exceeded the target range for all indicators used to measure performance. All quality requirements had been met on an ongoing basis since 2015.
- The service used key performance indicators (KPIs) that had been agreed with the ICB to monitor their performance and improve outcomes for patients. The service shared with us the performance data from September 2022 to August 2023 that showed:

- Clinical assessment within 20 minutes for walk-in patients: 97.81% against a target of 95%.
- Clinical assessment within one hour for walk-in patients 99.41% against a target of 95%.
- Consultations for Life Threatening Emergencies (LTE): 100% against target of 95%.
- Urgent consultations (2 hours) at a treatment centre: 93.83% against a target of 90%.
- Routine consultations (6 hours) at treatment centre: 99.24% against a target of 85%.
- Non-urgent consultations at treatment centre (12 hrs): 99.79% against a target of 85%.
- Consultations for an urgent home visit (2hrs): 93.16% against a target of 90%.
- Consultations for a routine home visit (6hrs): 96.25% against a target of 85%.
- Consultations for non-urgent home visits within 12 hours: 100% against target of 85%
- The percentage of patients whose post-event message was sent to their registered GP before the 8am deadline had continually scored higher than the KPI of 95%. Over the last 12 months, the lowest percentage was 98.71% whilst the highest was 99.88%. The service had scored above 99% every month since December 2022 up to the time of our inspection.

- 99.58% of patients who arrived at the service completed their treatment within 4 hours, against a target of 95%.
- 98.78% of patients who attended the service were provided with a complete episode of care. There was no target set for this.
- Only 6% of patients who attended the service were advised to attend A&E. There was no target set by the ICB for this.

- The provider met regularly with the service commissioners, the local ICB. Within this meeting, the provider presented how they met the quality schedule standards as required by the threshold. Interim meetings took place between the provider and commissioner quality leads to identify progress around the quality standards and address any concerns.
- As part of an emergency department clinical validation (this is for a defined cohort of patients that had been advised to attend an emergency department following an NHS 111 assessment but were alternatively offered a consultation with a senior DHU clinician), it was demonstrated that between 70-80% of patients assessed by a DHU senior clinician did not then require an emergency department attendance following their consultation.
- The provider had a dedicated internal audit team, and the medicines management team also had an active role supporting audit. We observed an active annual audit programme which included:

- Clinical consultation audits. There was an embedded system of audit to assess clinical performance using a tool developed by the Royal College of GPs (RCGP). All clinicians, including agency staff and GP registrars, were subject to an ongoing audit process to review their consultations and prescribing. The audits were conducted on a 3-tier system depending on potential risk. For example, new clinicians or any staff where a concern had previously been identified had at least 4 audits undertaken a month, whilst those who had been in post over a year with a good record of audit outcomes were audited monthly. Staff moved between the tiers, so if an identified issue was found to be showing improvement, the clinician moved from tier 1 to tier 2, for example. There were 10 clinical auditors who were experienced senior nurse practitioners that had completed additional training to support the role. All clinicians

received feedback on their audited consultations, which included a review of telephone consultations as well as documentation and prescribing. It identified any areas for improvement and gave a score, with 90% being the target. There was a right to appeal any fails and individuals were supported with an action plan and access to a training team. This robust programme to oversee clinical performance drove continuous improvement across the organisation.

- Antimicrobial audits.
- Quarterly audits of controlled drugs.
  - There was a rolling monthly programme for sepsis audits using sepsis and national early warning scores (NEWS) tools. Any identified concerns or opportunities for learning were fed back to individual clinicians and, if required, could be escalated to a clinical performance review.
  - Information governance audits.
  - Internal Organisation for Standardisation (ISO) audits to monitor the provider's accreditation in 3 standards (quality, information governance and business continuity)
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, as part of a forthcoming World Antimicrobial Resistance Week in November 2023, the medicines team were championing antimicrobial training by promoting learning materials and webinars available to staff.
- The service was actively involved in quality improvement activity. Further details are provided in the well-led section of this report.

Effective staffing

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

- The provider used a skill mix model across the service. The provider also supported GP registrars to work in the out-of-hours service and had clinical trainers on site to provided debrief/support to match individual need. GPs were supported to do the clinical trainers' course to act as trainers.
- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. Feedback from staff indicated that they had received a comprehensive induction with support over the first few weeks (for example, shadowing opportunities and an identified mentor) until they were confident within the role. New starters were offered a shadowing shift before starting work, and we saw an example of a signed induction checklist completed by a GP on one of these shifts to ensure their familiarity with a range of processes.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- There was a mandatory annual training programme consisting of safeguarding children and vulnerable adults; basic life support, infection prevention and control; health and safety; and data security awareness. We saw that clinical staff also had to complete annual sepsis training and undertake mental capacity act and Prevent (an early intervention programme to support people susceptible to radicalisation) training updates every 3 years. The provider was working on a plan to introduce learning disability and autism training on the mandatory schedule and staff induction process. For new staff, there was an expectation for all mandatory and statutory training to be completed within 3 months of appointment.

  The process was overseen by a mandatory training team governed by the nursing and quality directorate. The team's remit included monitoring training compliance training, and this was closely monitored to ensure that training was completed and updated within a defined timescale. Reminders were sent 3 months and then 1 month prior to the deadline for the update training to be completed. In recognition that many employees worked elsewhere in the NHS, staff were able to bring certification of their completed training from, for example a GP

practice or secondary care, and use this to evidence their training status. Agency staff also had to provide evidence of mandatory training which was checked by the organisation's recruitment team as part of their compliance checks. At the time of our inspection, we saw that 91% off staff mandatory modules were up to date ranging from a high of just over 96% for safeguarding and Prevent, to 82.6% for mental capacity.

- The provider ensured staff received ongoing support. This included 1-1 meetings, coaching and mentoring, clinical supervision and support for revalidation. The organisation's performance appraisal procedure stated that 1-1 meetings between line managers and staff should take place at least bi-monthly. Managers and team leaders had a more structured approach to 1-1 meetings, whilst clinical and non-clinical staff arrangements were more ad hoc and were in the form of either clinical supervision, catch-ups with their manager, or team meetings.
- The service promoted but did not enforce clinical supervision as it was subject to an individual's personal preference. We saw that posters were displayed in clinical areas to highlight how to access supervision, and staff were allocated time for supervision if they wished to attend. The sessions were mostly on a 1-1 basis, although group supervision could be arranged on request. Salaried GPs could also request a 1-1 support session with a deputy clinical director. Individuals could be directed to attend supervision if an issue had been identified via audit, an incident or a complaint. From January to August 2023, 83 hours of face-to-face supervision had been delivered and 39 hours of telephone supervision across the organisation.
- All staff received a comprehensive induction and received training to undertake their role effectively. Probationary reviews were held with the employees after 6 months prior to their ongoing employment being agreed.
- There was an annual appraisal programme and the development of key objectives in line with the organisation's values. This provided an opportunity to identify any training needs. Staff we spoke with told us that they had found the appraisal process beneficial. At the time of our inspection, 92.5% of employed staff had received an up-to-date appraisal.
- There were career development pathways for staff. For example, 2 or 3 nurses each year were supported in development roles to move onto an advanced practitioner junior role, which could then lead to attaining an advanced practitioner role in the future. Health care assistants also had opportunities to develop from a band 2 role to band 4 as assistant practitioners scheduled within the next few months.
- Educational monthly sessions were arranged in the evening for staff. These were added to the intranet to enable those unable to attend to access later. We saw the most recent training event had been in relation to safeguarding referrals, and the next focused on interpreting blood results.
- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. We observed examples of this including ongoing supervision following a data review and an identified learning opportunity for an individual that had since improved their overall performance.
- The responses from the 27 staff questionaries we received showed that most staff were given the opportunity to attend training courses. They told us that regular opportunities for continuous professional development were provided in the form of training sessions hosted by in-house staff and external expert speakers. Staff also said they had received training specific to their role and most of those who held a professional registration told us they were supported in the revalidation process.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The monthly attrition rate of employed staff working for the out-of-hours service was low and we saw that this was also on a trajectory of continuous improvement. Between April and August 2023, the attrition rate ranged from 0.6% to 1.6%, and in the previous 6 months the average ranged from 0.2% to 2.7%. Good retention rates meant greater stability for the service.

Coordinating care and treatment

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

Outstanding ☆

Are services effective?

- Patients received joined up person-centred care. Clinicians had access to special notes and shared care records for those at risk, or with complex health and social care needs.
- Special notes were developed for high impact and high frequency users in collaboration with appropriate external agencies including primary care, the emergency department and ambulance services. This enabled a management plan to be formulated to better address their individual needs. The out-of-hours service looked at those patients who contacted them 5 or more times in a month, although this took account of those with complex health needs. We saw evidence of the impact of this review, for example we saw that a patient with complex needs had contacted the service 246 times in 2022, but following the special notes/care plan being developed this had reduced to 40 contacts in the first 9 months of 2023. A patient with learning disabilities had a reduction from 80 contacts in 2022 to 8 at the time of the inspection in October 2023.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GPs 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. The service worked with patients to develop personal care plans that were shared with relevant agencies.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and 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 patients that required 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.
- The provider supported influenza and COVID-19 vaccination programmes across Derbyshire vaccinating 10,000 care home residents/staff, and 5,000 housebound patients.
- The provider had undertaken outbreak swabbing and/or prophylaxis on behalf of the UK Health Security Agency (UKHSA). This included influenza, COVID-19, scabies, diphtheria and Strep A (a common type of bacteria).
- Where appropriate, staff gave patients advice so they could self-care.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. This was evidenced by discussions with clinical staff.
- 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.

Outstanding ☆

Are services caring?

We rated the service as outstanding for caring. This was because:

- The provider championed systematic and innovative approaches to gain feedback from patients across all their different services in multiple ways, and at each stage of the care pathway. This included vulnerable, challenging, and hard to reach groups to ensure that all voices were heard and represented.
- Feedback from patients demonstrated that they consistently rated their experience of using the service highly. This included being given information about their condition; being given sufficient time during consultations; and feeling reassured following a clinical consultation.
- The provider supported charities acting in line with its values and its community interest company status.
- We found that all aspects of work undertaken by the provider were based around the patients' needs with a focus on either improving health; or providing holistic support and compassionate care for those at end of life.
- The provider demonstrated a strong committed to promote and support staff welfare. A range of services were available to promote good health, and to support those who may need additional physical or mental health support.

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 patients with specific health care needs such as those who had mental health needs. Patients requiring end of life support were given priority and were managed by appropriately trained staff.
- The service extensively monitored patient feedback via a range of measures. These were analysed by each individual service and site monthly.
- We spoke to 3 patients who attended the Ashgate Manor out-of-hours service on 16 October 2023, and 3 more patients at the New Mills Walk-In Centre on 17 October 2023. We spoke to the patients following their consultation, and all were very satisfied with the service they had received. We observed that the 3 patients at Ashgate Manor were seen on or close to their appointment times; 3 walk-in patients at New Mills waited between 2-15 minutes. They informed us that they were very impressed with the service and that all the staff they encountered treated them with compassion, dignity and respect. They felt informed and involved in their care and treatment.
- The provider worked with staff to support local charities.

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. Information leaflets were available in different languages, easy read formats, and large print, to help patients be involved in decisions about their care. Staff communicated with patients in a way that they could understand, and communication aids such as hearing loops were available at all sites.
- As part of the extensive patient experience surveys undertaken, patients were asked a range of questions in order for the service to understand the demographics of their population. This enabled the provider to adapt services to accommodate these needs. For example, patients were asked about their age, ethnicity, and physical disabilities including sensory and hearing difficulties.
- Patients felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. For example:

Outstanding ☆

Are services caring?

- Patient survey data from April to September 2023 for the home visit service showed 94.5% of 238 respondents felt involved in any decisions that were made.
- At Ashgate Manor 95.6% of 453 respondents reported positively about the length of time with the health care professional who saw them (April-September 2023).
- 97.4% of 77 respondents who had accessed the out of hours service at Buxton were positive about the health care professional's explanation to them about their condition (April-September 2023).
- At Ashgate Manor 93.4% of 453 respondents reported positively that they felt reassured following their consultation with the health care professional (April-September 2023).

We observed that the results were very similar across all sites where the service operated.

- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- 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.

Privacy and dignity

The service respected and promoted patients' privacy and dignity. This was confirmed by the responses from patient surveys which showed results consistently averaging between 95-100%.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making. We spoke with nursing staff who were able to describe the Gillick competencies and Fraser guidelines (Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment).
- 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. Staff were aware of their responsibilities in respect of patients who had been identified as being not for cardio-pulmonary resuscitation.

Outstanding ☆

Are services responsive to people's needs?

We rated the service as outstanding for providing responsive services. This was because:

- The provider demonstrated a proactive response to develop solutions in adapting or providing new services as required. We saw many examples of this, including a comprehensive response during the COVID-19 pandemic to provide vaccinations, and to deliver treatments to patients in the most appropriate environment.
- The service worked collaboratively with other services, professionals and agencies to provide co-ordinated, multidisciplinary care for vulnerable patients. The provider was able to evidence a positive impact of their service, for example, by ensuring homeless patients received the COVID-19 vaccination.
- The introduction of a palliative care urgent response service (PCURS) had produced responsive and effective patient-centred care for individuals in their home environment. The evaluation of this service had demonstrated a service highly valued by patients and their families.
- Data demonstrated that the provider had a proven record of meeting, and usually exceeding, performance targets to see patients quickly in the out-of-hours service.
- Patients provided positive feedback with regards to their satisfaction in terms of waiting times to be seen.
- We observed that patient complaints were dealt with effectively and used to implement learning when appropriate. The provider offered additional support to the standard complaints process, by offering direct input from the medical director to help resolve complex complaints.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and tailored services in response to those needs. For example, the provider had responded rapidly and effectively to the COVID-19 pandemic and established vaccination services, for example:

  The provider had proactively developed and mobilised services to support the COVID-19 pandemic supporting the wider health regional network including:

  - Countywide 'red' hubs and an acute visiting service. This had provided care for 20,000 patients across 3 sites and delivered 10,000 home visits across Derbyshire. This had a significant impact on hospital admissions with less than 5% of this cohort attending hospital or the Emergency Department.
  - Winter/acute respiratory infection hubs. There were 9,000 appointments provided across 9 hubs in Derbyshire, and of these 85% of patients managed with self-care or treatment and less than 4% resulted in a hospital admission.
  - 2 large scale lateral flow testing drive-through swabbing centres delivering 86,000 PCR tests.
- The provider had also established a covid medicines delivery service for the early supply of antivirals and neutralising antibodies in the community. This commenced in March 2021, working with the wider Integrated Care System (ICS), and had been extended up until March 2024. Patients self-referred into the service and were contacted within 24 hours. The patients were subject to advanced clinical triage, and treatment where appropriate. The service ran from 8am to 6pm every day, and to date 8,000 patients have been triaged (all within 24 hours) with over 1,000 courses of antiviral treatment, and over 1,000 patients received intravenous antibody treatments. Data suggests that early treatment reduces the risk of hospital admission and mortality by up to 87%. The service was nominated for an Urgent Health UK Collaboration Award 2022, and received highly positive feedback from patients.
- The provider had developed a COVID-19 oximetry at home/virtual ward service for patients. Commencing in December 2020, a total of 2,434 patients had been successfully managed in the first 2 years with evidence of admission avoidance

and early discharge from hospital. In October 2022, the scheme was adapted into a community respiratory virtual ward of 60 'beds'. There had been 756 patients enrolled onto the scheme since it began with less than 1% resulting in hospital admission. In June 2023, a virtual ward palliative care scheme was launched with 15 'beds', and at the time of our inspection 145 patients had benefited from this service.

- The provider engaged with commissioners to secure improvements to services where these were identified. For example, the provider had introduced a palliative care urgent response service (PCURS) in 2019 as a pilot daytime service at weekends. This was later extended to 8am to midnight, every day. The commissioners were unable to provide permanent funding for the scheme and therefore from July 2023, the provider had directly funded the scheme although it has had to be scaled back to weekends and bank holidays only from 8am to 6pm. This was one of many examples we saw in which the provider was constantly reviewing and adapting services to meet changing demands and patient need.

  The PCURS service has been very successful with 2,664 patients being seen between September 2022 to July 2023. This included children and the service had supported 8 families in their wish for their terminally ill child to die at home in this time. In addition:

  - 98% of patients referred to the scheme were triaged within 1 hour of request.
  - 95% were cared for in their preferred place.
  - 96% service users stated they were either satisfied or extremely satisfied with the care they had received.
  - Less than 1% required hospital admission and 5% of patients/families said they would have called 999.

  All of these were all significantly above the key performance indicator (KPI) targets set for the service. For example, the user satisfaction KPI was 75%.

  The service had also developed patient stories in the forms of short videos. We viewed 2 of these in which we saw relatives speak of the exceptional care provided for their loved ones. The videos demonstrated the support they had received personally from the PCURS team helping them to cope with the situation, and providing comfort in knowing that their relative was being supported to die peacefully without pain, in their own home.

  When the service was scaled back, the provider hosted an afternoon tea for staff to celebrate what had been achieved and to thank the team. This was attended by many senior managers and members of the Board.

  The service was shortlisted for the Nursing Times Awards and East Midlands Business Awards in 2022.

- The provider improved services where possible in response to unmet needs.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a patient using the service. The service was able to access special notes relating to the patient's health and social circumstances to inform decision making. 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 were appropriate for the services delivered. The premises facilitated easy access for those patients with a disability. The service was spread across the county which meant patients did not have to travel excessive distances to receive out of hours care.
- The service was responsive to the needs of people in vulnerable circumstances. For example, we saw how the service had supported homeless people to receive the vaccination during the COVID-19 pandemic. They had also taken actions to provide vaccination support for approximately 250 homeless people (who also received the second booster jab). DHU had worked with agencies to identify and track homeless individuals, and information was stored on their patient record system linking to the national database if the person was not registered with a GP.

Outstanding ☆

Are services responsive to people's needs?

- If a patient did not attend for an appointment and they were considered vulnerable, the GP called them to manage the risk and provided a home visit if that risk escalated. They also organised a safe-and-well check to ensure the safety of patients.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The various sites had different opening times, but the main site at Ashgate Manor opened between 6pm and 8am Monday to Friday, and 24 hours at the weekend and bank holidays. Home visits were also provided for those patients who needed out-of-hours care but could not travel to one of the sites.
- Patients could access the out of hours service either via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment at all sites as some sites offered a walk-in service.
- Patients were seen in line with their allocated appointment times, and if the site saw walk-in patients, they were generally seen on a first-come first-served basis. However, the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the red flag symptoms that would prompt an urgent response. The receptionists mostly informed patients about anticipated waiting times. Information was displayed on waiting times in some units, and specifically where a walk-in service was offered.
- We saw that 95.6% of 453 patients who responded to a patient survey for the Ashgate Manor site (April to September 2023) stated that they have a good/very good or excellent experience in terms of the waiting times. Just under 75% reported an excellent experience in terms of their wait.
- For the home visiting service, we saw that 241 patients had responded to the patient survey between April and September 2023. Of those responses 44.8% reported an excellent experience in terms of the length of time for the health care professional to arrive, whilst 26% said their experience was very good, and 15% said good.
- 20-minute appointments were provided with a GP or advanced practitioner at all sites delivering out-of-hours consultations. This enabled enough time for the clinician to assess the patient adequately and review their past medical history and any special notes. At some sites, a health care assistant saw the patient initially to undertake observations such as blood pressure and oxygen saturation levels to inform the clinical review.
- We saw the most recent local and national key performance indicator (KPI) results for the service (September 2022 to April 2023) which showed the provider was meeting the following indicators:
  - The percentage of patient with a life-threatening emergency, receiving a face-to-face consultation at a primary care centre within one hour, achieved 100% every month against a KPI of 95% (57 patients in total).
  - The percentage of patient with an urgent health requirement, receiving a face-to-face consultation at a primary care centre within 2 hours, met the KPI of 90% on 10 of the preceding 12 months. It averaged at 93.8%. Performance dropped slightly below the KPI to 85.31% and 89.39% in November and December 2022 respectively.
  - The percentage of patients receiving a routine face-to-face consultation at a primary care centre within 6 hours, exceeded the KPI of 85% each month. The lowest percentage was 96.82% in December 2022. Since February 2023, the service had achieved more than 99% compliance against the target each month.
  - The percentage of patients requiring a face-to face consultation via a home visit within 2 hours met the KPI of 90% on 11 months. The performance was minimally below the KPI at 89.16% in February 2023, but averaged just over 93% in the 12-month period.
  - The percentage of patients requiring a face-to face consultation by means of a home visit within 6 hours met the KPI of 85% every month. The lowest monthly performance was 93.14% in June 2023 which still exceeded the KPI by over 8%. The average performance over the 12-month period was just over 96%.

Outstanding ☆

Are services responsive to people's needs?

  - The number of patients presenting as walk-ins who received an urgent consultation within 20 minutes was 113 out of 117. This equated to 96.6% over the 12 months, against a KPI of 95%.
  - Performance for non-urgent consultations at treatment centres (12 hours) averaged 99.8%, and for non-urgent home visits (within 12 hours) was 100% against targets of 85% for both.
- Where the service was not meeting the target, the provider was aware of any shortfalls and took action to address them.
- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support patients while they waited. For example, if home visits were delayed, comfort calls were made to check on the patient, and to provide reassurance and safety netting advice.
- The service engaged with people who were in vulnerable circumstances and took actions to remove barriers when patients found it hard to access or use services.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

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 complaint policy and procedures were in line with recognised guidance. The service had received 55 complaints in the last year. We reviewed 5 complaints and found that they were satisfactorily handled in a timely way, although there had been some delays during the pandemic which had affected all NHS services' complaint response times. Where relevant, complainants were proactively invited to a meeting with the medical director or an appropriate other senior clinician regardless of whether or not they were satisfied with the written response. The provider informed us that when this had happened, it had been very effective in providing the assurances sought by the complainant and had concluded the complaints process in each case. We also saw an example where the medical director had provided a further written response to clarify issues for the complainant in more detail as they had indicated they remained unhappy after receiving the response.
- Complaints were monitored for trends and themes and were reported through various meetings as part of the provider's governance structure. The service learned lessons from individual concerns and complaints and acted as a result to improve the quality of care.
- We saw examples where actions had been taken in response to complaints. For example, new signage was put up in waiting areas to help patient's understanding and their expectations of the service provided at Chesterfield Royal Hospital in acknowledgement that pathways in the department could be confusing.

Outstanding ☆

Are services well-led?

We rated the service as outstanding for leadership. This was because:

- The leadership, governance and culture within the service drove improvements to deliver high-quality person-centred care. This included collaborative partnerships, and multidisciplinary and multiagency working which supported patient care. The provider was able to demonstrate the positive impact this had on health outcomes for under-represented populations such as homeless people.
- We observed a values-driven approach with the organisational values underpinning all aspects of how the service worked. Staff interviews and questionnaires demonstrated the provider's CARE values were embedded and part of the culture.
- Leaders strove to deliver and motivate staff to succeed and to develop. Staff feedback was highly positive about the support provided to staff, and staff were proud to work for the service.
- Staff development was actively encouraged at all levels. The 'Inspire' programme for managers had a very positive effect on personal and managerial development.
- The provider was committed to support staff welfare, and we saw that a range of services were available to promote good health, and to support those who may need additional physical or mental health support.
- We saw that patients were at the heart of everything the provider did. Patient views were actively sought to help continually adapt services to deliver the best possible experiences for patients.
- The provider embraced innovations and proactively sought out and embedded new ways of working to provide care and treatment to a diverse population.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders demonstrated a passionate, enthusiastic, innovative, and patient-focused approach to how the service was delivered and developed.
- Managers had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. We identified that the provider was proactive in responding to challenges that faced both themselves and the wider health community, fostering a 'can do' attitude and adopting a positive approach to reach a solution.
- Clinical and operational leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management were accessible throughout the operational period, with an effective on-call system that staff were able to use. Clinicians were able to access clinical advice from the clinical lead on duty at any time during their shift.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The provider had developed Inspire, an externally facilitated rolling in-house programme for managers. Approximately 120 managers had already completed the programme and further cohorts were undertaking the programme. We spoke with several managers who had completed the training. They all highly praised the programme and stated the personal impact this had upon them and reflected that they had been both developed and inspired in their roles as a consequence. Some managers were doing coaching mastering to take over training to deliver this in-house in the future. Members of the Board including non-executive members were also completing the Inspire programme. As Inspire was directed towards higher-level management, plans were evolving to introduce an Aspire programme for other staff to develop their skills and promote their personal development.

Outstanding ☆

Are services well-led?

- The organisation had a highly developed infrastructure with managers and teams to oversee specific areas of responsibility. This was supported by divisions to manage corporate functions such as information technology (IT), human resources and finance. Clinical services were overseen by a medical director, clinical director, 2 deputy clinical directors and a head of clinical services. There were named clinical leads and clinical service leads for each profession and staff group.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. The provider monitored progress against delivery of the strategy.
- The organisation had developed CARE (compassionate, accomplished, respectful and encouraging) values. We saw these values were embedded into how the service operated and were cascaded to staff as part of their annual appraisal.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The services provided focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. We were provided with examples when this had taken place.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. Responses received from our staff questionnaire indicated that staff were aware of whistleblowing and Freedom to Speak Up policies on the organisation's intranet. One staff member stated that they were fearful of raising concerns, but all other 26 respondents to our staff questionnaire indicated that they were comfortable escalating issues and felt supported in doing so either through the online system, via their line manager or at team meetings. Most staff felt concerns raised would be looked into and feedback given. Regular communication newsletters were sent out to staff throughout Freedom to Speak Up month to highlight awareness of the role.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff. The provider was committed to actively promote staff welfare and had arranged a number of schemes to support employed staff's physical and mental health. This included occupational health services, access to mental health support (including mental health and suicide first aiders), and counselling. In addition, the organisation promoted staff health awareness sessions including the menopause and men's health roadshows.
- The organisation had developed a 'People Offer' consisting of:

- Holistic well-being (access to an independent health and well-being company contracted by the provider for employees, including counselling, physiotherapy and savings on dental care). Family members could also be added onto the employee scheme.
- Improving staff retention by matching the NHS offer, for example in terms of pay and benefits such as paternity leave. 'Stay' questions had been introduced into staff appraisals to seek what issues were important to each individual so the organisation could do their best to retain the employee working for them.
- Nurturing talent by providing opportunities to develop. We were provided with examples of how this was enabling nursing and health care assistant staff to progress to new roles.
- Enhancing patient experience, recognising that happy employees will do their best for patients.

- Staff long service awards were provided at intervals of 5,10,15 and 20 years of service. The organisation also ran CARE awards in which staff could nominate individuals for achievements in line with the organisational values.
- Employee forums were in place as well as support groups, for example, armed forces (the organisation had achieved NHS Veteran Aware Accreditation in 2023), and lesbian, gay, bisexual, transgender, intersex, queer (LGBTQ) employees.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally. The organisation promoted Black History Month, World Mental Health Day, and Neurodiversity Celebration Week.
- There were positive relationships between staff and teams.
- Staff were supported when they were involved in a traumatic incident, complaint or investigation.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- The organisation provided standard operating procedures and guidelines to support the management of the service both operationally and clinically. The organisation had an established governance structure that spanned from divisional level up to the Board to ensure oversight and assurance of the services provided.
- We observed that the structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- A quarterly Clinical Quality Review Group meeting took place with service commissioners. Agenda items included audit updates, actions taken in response to NICE guidance and safety alerts, and an analysis of complaints and patient safety incidents.
- Other meetings supported the oversight of effective governance, including a monthly urgent and emergency care clinical governance and risk register committee. This meeting received reports from various sub-committees and other groups, as well as reviewing feedback on areas such as complaints and significant events.
- There was a range of different staff meetings held across the organisation to share important information, raise any concerns, and coordinate working arrangements. We saw that comprehensive minutes were recorded and that actions were followed up until completion.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established effective policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Policies were readily accessible on the organisation's intranet, and we saw that policies were regularly reviewed and updated.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Outstanding ☆

Are services well-led?

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The organisation maintained a live risk register which logged all areas of known or potential risk with a defined risk rating. These issues were subject to monthly monitoring at a risk review meeting attended by senior management to mitigate or reduce risk, and wherever possible to resolve the concern. There was a process to escalate any extreme risk to executive level.
- A weekly incident escalation meeting reviewed any concerning cases for decision on escalation. There was an escalation process for any problems that could not be resolved at operational level. These were notified via a bronze, silver and gold escalation process depending on the nature and potential impact of the presenting issue. For example, the service had experienced a long-term outage of their patient consultation software due to an NHS-wide cyber security issue, and this was escalated to gold command where the business continuity plan was implemented. We saw that despite the widescale disruption this created, the issue was well-managed and did not impact on the continuity of frontline patient services.
- The provider contributed to a meeting across the county each morning to consider any presenting or potential pressures to try and resolve this through a whole systems approach. For example, in the recent doctors' strikes, the provider had been able to assist with some measures to try and manage the impact of the strike.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Performance was monitored on an ongoing basis and all managers received a daily report, for example, detailing the number of patients seen within the required timeframe as part of the NQR and key performance indicators (KPIs). Any patients not seen within KPIs were reviewed to find out why the target had not been met and any corrective actions were applied and learning points were shared. Leaders had oversight of safety and medicines alerts, incidents, and complaints. Leaders also demonstrated a full understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local integrated care board as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The provider had plans in place and had trained staff for major incidents. There was a detailed business continuity plan which was regularly updated to reflect changes and in response to any events that had occurred. For example, the plan had been pivotal to managing a long-term outage of the patient consultation software, and updates were made to the plan later to reflect the learning applied from this event. The business continuity plan was a standing agenda item at the clinical lead's meeting. Scenario planning was arranged for clinical and operational managers to enhance responsiveness to any high-level incidents impacting on service delivery. The organisation had received Internal Organisation for Standardisation (ISO) accreditation for business continuity.
- The provider took part in desk-top national planning exercises to test systems and to adapt for preparedness to new system-wide issues, working in collaboration with other organisations and agencies.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care. This was demonstrated by the changes made to the PCURS service described previously.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.

Outstanding ☆

Are services well-led?

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- 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. The organisation had achieved Internal Organisation for Standardisation (ISO) accreditation for information security, and we were provided with a large volume of evidence to demonstrate their compliance with this.
- There was a named Caldicott Guardian for each part of the organisation, including Derbyshire. (The Caldicott Guardian is a senior person responsible for ensuring that personal information is used legally, ethically and appropriately, and that confidentially is maintained). Information was readily available to staff to highlight the role of their named guardian.

Engagement with patients, the public, staff and external partners

A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The provider displayed a strong commitment to seek feedback about the services provided. The organisation conducted surveys, gathered patient feedback, and engaged with patients to gain insights into what they valued most. A variety of feedback mechanisms had been implemented to ensure that patient voices were heard, including visible 'share your views' leaflets and friends and family cards in patient areas including a post box for submissions. The friends and family cards included a QR code so that patients could complete their feedback online. CQC 'Give feedback on care' posters were also prominently displayed. In addition, patients were contacted after using the service with a text message containing a link to access the feedback survey. Other sources of information were also used to collate feedback including the NHS website, information from other providers, and social media.
- All feedback received was analysed to review trends and themes, and potential areas for improvement. The organisation implemented changes in response to the feedback received, and we saw many examples of this including:
  - The installation of a waiting time electronic board at Ashgate Manor in response to feedback about occasional long waits with no explanation.
  - A patient 'calling card' was implemented to aid communication. For patients who might not have remembered a home visit had taken place, the card alerted carers or family members of this, and provided service contact details. The card was used for home visits, and also at the various sites for face-to-face consultations when needed. It could also be used as a calling card to inform patients that the service had visited the patient's home, but no one was there.
  - A self-care leaflet was introduced for patients who were signposted to a pharmacy for medicines that could be purchased over the counter. This was in response to a perception that an attendance did not result in a prescription being issued, but rather being redirected to go to a pharmacy (in line with guidance to reduce the prescribing of over-the-counter medicines and products).
- The organisation held a patient and public involvement sub-committee every 2 months which formed part of the governance reporting structure. We spoke with 1 of the 2 lay representatives on the committee who told us that their views were respected and valued, and felt that the organisation was strongly committed to listen to what patients said.
- As part of inspection, we asked staff to return a questionnaire to ask about their experience of working for the service. We received 27 staff responses from across the service.

Are services well-led?

Most respondents said they were involved in staff meetings and received regular communication via email and newsletters. The majority stated that communication with management was open and transparent and that regular updates were given.

Staff overwhelmingly feel supported by their immediate line manager. The words supportive, caring, approachable, understanding were used by those who responded.

Only 1 respondent stated that their views were not listed to or acted upon. All others who responded stated that their suggestions were taken on board and some of the time acted upon. For example, an employee told us that staff at the phlebotomy clinics suggested an increase in the time allocated for taking blood from children. This was reviewed by managers resulting in the slot times being changed following an initial audit.

- The provider undertook an annual staff survey. We saw evidence of the most recent annual staff survey and how the findings were fed back to staff. For the last 2 years, the organisation had used the same staff survey as the NHS allowing the overall results to be compared against the wider NHS. There were 2,196 DHU staff invited to complete the survey in 2022 and there was a response rate of 51%. The results were positive and indicated that:
- 68% of DHU respondents recommended the organisation as a good place to work, compared to 57% in the NHS results.
- 83% of DHU respondents were happy with the standard of care provided by the organisation, compared to 63% in the wider NHS.

DHU also performed slightly higher than the wider NHS in 8 of the 9 themes relating to the NHS People Promise (a pledge **to work together to improve the experience of working in the NHS for everyone). The organisation only scored 0.1% lower than the NHS on 1 theme relating to individual responsibilities, being trusted to do the job, and using initiative in the workplace. The organisation was in the process of developing actions in response to the outcomes of the survey.**

- **We saw that the organisation had taken a proactive response to the previous year's staff survey results in 2021. Staff said they wanted the organisation to develop a culture to give everyone a voice, where leaders trust staff to deliver their responsibilities and empowered them to make improvements. The Board committed to create a coaching culture in response and following a couple of pilots, the Inspire leadership programme was launched in March 2023 in partnership with an external leadership development company. To gauge the success of the programme, 6 statements were incorporated into the 2023 survey. These showed a relatively good response and acted as a good marker over the next 12 months to be able to assess the impact of the programme when it was more established.**
- During our 3 days on site, the inspection team spoke with many members of staff including clinicians, managers, non-clinical staff and locums. We received overwhelmingly positive feedback about the provider and employees and agency staff said it was a good place to work. Clinical staff were very positive about the support and clinical advice they received which was readily available, even if working at a remote location. Staff commented that they felt valued and that the relationship with their line manager and senior leaders was marked by trust, open communication, and continuous support. They stated that there were numerous opportunities for growth and advancement with the organisation. They commented that it was a great place to work that embodied the values of empathy, compassion, collaboration, and growth. In relation to interactions with patients, staff stated that the patient experience was at the heart of everything that DHU did and that all staff were responsible for creating a compassionate and patient-centred culture.

Outstanding ☆

Are services well-led?

- The service was transparent, collaborative and open with stakeholders about performance. Managers had regular meetings with their commissioners to review performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the service.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- There was a strong culture of innovation evidenced by the number of schemes the provider was involved in. There were systems to support improvement and innovation work. We saw many examples, some of which have been described in the responsive section of this report. In addition:
- The provider had a proactive approach to the sustainability agenda and supported green initiatives. A green inhaler initiative was introduced in August 2022 when the service started to stock only low-carbon inhalers and supported this with advice to prescribing clinicians. Prescriptions for standard Ventolin inhalers fell from 100% in April 2022 to 16% in March 2023. This was monitored via ongoing audits and staff education.

  In addition, the vehicles used for out-of-hours GP/ANP home visits and community nursing visits were hybrid vehicles to reduce carbon emissions. Trackers had been fitted so that if visits were needed whilst the teams were out on the road, these could be allocated to the nearest vehicle to reduce mileage. The organisational aim was to achieve carbon net zero by 2040.

- The provider was part of a pilot primary care streaming service co-located with urgent care services at Chesterfield Royal Hospital. When adult patients arrived at the main entrance to the Emergency Department (ED), they received a streaming assessment from a DHU clinician. The streaming assessment includes a brief assessment of their condition with the completion of basic observations with patients then being transferred to the appropriate receiving area within the ED, referred to an assessment unit, or to the urgent treatment centre. This service operated 7 days a week from 8am to 11pm and helped to alleviate pressures on ED. In August 2023, a total of 1,380 patients used this service.
- A Clinical Navigation Hub (CNH) run by the provider supported the ambulance service with their volume of calls by assessing patients to see if they could be treated elsewhere. This pilot introduced in December 2022 has been extended until April 2024. Data to date demonstrates an average deflection from primary care of 87%, and 18% of patients being managed with self-care advice.
- At the time of our inspection, the provider was starting a point of contact for tetanus testing. For example, they saw many farm injuries at the Buxton site due to the rural nature of the area. The tetanus testing would able them to determine if a patient had immunity to tetanus, and if not they would be referred to their GP to receive the vaccine.
- DHU had gone through a process of compliance with certain Internal Organisation for Standardisation (ISO) standards to ensure that they were able to demonstrate to service users, commissioners, and stakeholders that they provided the highest quality of services and support practicable. The achievement of the ISO standards showed the organisation's commitment to organisational improvement and development. These were for Quality Management (ISO 9001), Information Security Management Systems (ISO 27001), and Business Continuity (ISO 22301).