Bucks & Oxon Divisional HQ – South Central Ambulance Service

Quality Report

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a focused inspection of the NHS 111 service provided by South Central Ambulance Service NHS Foundation Trust on 11 and 12 November 2015. We visited both sites located in Bicester, Oxfordshire and Otterbourne, Hampshire. This was a focussed inspection to focus on the specific areas of the media coverage. Please note that the full key lines of enquiries and domains were not reviewed.

The Care Quality Commission (CQC) carried out this focused inspection as a result of an undercover reporter's media article on 1 July 2015 which raised concerns about the way the NHS 111 service was operated by South Central Ambulance Service NHS Foundation Trust. The concerns included alleged inappropriate use of systems and processes, for example, inappropriate referrals to the 999 service. The article also raised concerns relating to recruitment processes, inadequate staffing levels, lack of staff training and support, and the way complaints and significant events were managed. There were also concerns raised about how governance was managed, general leadership of the organisation and the processes in place for staff feedback.

The trust had notified CQC of the media interest prior to its publication and has subsequently kept CQC informed of the progress of the investigation. We inspected after the Trust had put into place a number of actions following their investigation.

The NHS 111 service provided by South Central Ambulance Service NHS Foundation Trust was a telephone based service where patients were assessed, given advice or were directed to a local service that most appropriately met their needs. For example, this could be an out-of-hours GP service, a NHS walk-in centre or urgent care centre, a community nurse, the emergency department at their local hospital, an emergency dentist, emergency ambulance or late opening chemist.

Our key findings were:

The South Central Ambulance Service NHS Foundation Trust provided safe, effective, responsive and well-led services.

- The provider had suitable systems in place to monitor safety over time, which included learning from incidents and complaints. For example, the investigation performed by the provider showed that of the specific issues raised by the newspaper, none had been substantiated to give significant cause for concern over the safety of the service that the Trust provided. These judgements had been externally reviewed by the Commissioning Clinical Governance GP leads. However, the Trust acknowledged that other issues had been identified during the course of the investigation which did give cause for concern and had resulted in changes and improvements being made.
- Staff understood, were provided with sufficient time and fulfilled their responsibilities to raise concerns and report incidents.
- The service was monitored against the Minimum Data Set (MDS) for NHS 111 services and adapted National Quality Requirements (NQRs). These data collection tools provided intelligence to the provider and commissioners about the level of service being provided. Action plans were implemented where variation in performance was identified. National data collection and monitoring showed the 111 service was being managed effectively.
- The provider had responded promptly to concerns received and had proactively used the information to review systems and processes and further improve service provision.
- Patients were assessed and treated in line with best practice and current national guidance using the latest version of NHS Pathways and NICE guidelines. (NHS Pathways is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call).
- There were effective day to day working arrangements within the service, with staff having clear roles and responsibilities. Staffing levels and skill mix were well managed. Systems were in place to manage peaks in demand.

Summary of findings

- There was a robust recruitment process in place. Staff had access to an improved training and induction programme. Systems were in place for ongoing support and coaching.
- Communication through the organisation had continued to improve following the investigation. Staff felt supported and well informed following the investigation and felt able to freely offer feedback.
- Staff were trained and monitored to ensure they used the NHS Pathways safely and effectively. (NHS Pathways is a licenced computer based operating system that provides a suite of clinical assessments for triaging telephone calls from patients based on the symptoms they report when they call). Systems were in place to mentor new staff members until they were competent in its use. Staff were then continually monitored. Regular updates of the clinical NHS Pathways were undertaken.
- Patients were involved in care and treatment decisions and consent. Staff knew the action to take if a person's capacity to make decisions was in question.
- The provider worked with the lead Clinical Commissioning Group and NHS England to respond to and meet patients' needs and had involved them following the investigation.
- Staff had access to best practice guidance and a Directory of Services. These documents were well maintained and kept up to date by a designated member of staff.
- The vision and values of the service had been communicated well to all staff members. Staff were positive about the continued improvement of quality of care they provided for patients and told us they were proud to work for the trust. Staff said morale had improved in the last three months and had welcomed the additional support offered.

However, there were also areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Introduce a robust system to ensure all staff records are updated when they have read updates to current guidance and policies.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The provider had suitable systems in place to monitor safety over time, which included learning from incidents and complaints. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and told us they had sufficient time and support to fulfil this role. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Lessons were learnt and areas identified for action as requiring improvement were communicated to all staff members.

Staff demonstrated understanding of the whistleblowing process and their roles and responsibility to report safeguarding concerns.

The provider had adequate arrangements in place to respond to emergencies and major incidents.

Robust recruitment processes were followed and arrangements were in place for planning for and monitoring the number of staff and mix of staff needed to meet patients' needs.

Are services effective?

Patients were assessed and treated in line with best practice and current national guidance using the latest version of NHS Pathways. Training on use of the NHS Pathways was comprehensive and systems were in place to monitor and mentor new staff members until they were competent in its use. Staff were able to receive other training appropriate to their roles. Further training needs were identified and planned for through the appraisal system. Intelligence monitoring tools were used to analyse outcomes of calls received to ensure treatment was relevant and effective.

Staff appreciated the improvements in support provided by individual coaching following the investigation.

There were suitable systems in place to manage incoming and outgoing information from the service to other stakeholders and to health and social care professionals.

Effective processes were in place to gain and record patient involvement and consent.

The provider used data to monitor performance and outcomes for patients. For example, data from the national situational report (SITREP) in November showed that the service had been performing better than other 111 services nationally.

Summary of findings

Are services caring?

We did not look at whether the service was caring as that was not required for the focused inspection. Other patient outcomes are included within other areas of the report.

Are services responsive to people's needs?

The provider had taken prompt and appropriate action in response to the concerns received. Systems were in place to monitor outcomes from complaint and significant event investigations. There was an accessible complaints system with evidence demonstrating that the provider responded quickly to issues raised.

The provider worked with external organisations appropriately and openly. For example NHS England and the clinical commissioning groups (CCG). An overview of complaints was maintained to monitor any trends and action plans were developed if required.

The provider used a directory of services, (DOS), which was well maintained and kept up to date by a designated member of staff. The directory of service detailed what treatment options were available for patients.

Are services well-led?

The vision and values of the provider had been communicated well to all staff members and additional training on this and leadership styles had been provided for all staff following the investigation. There were effective governance arrangements in place. The 111 service was well led and staff were aware of their roles and responsibilities. Staff told us the leadership, support and morale improved in recent months.

The provider monitored activity and regular governance meetings had taken place, which included systems to monitor and improve quality and identify risk.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

Introduce a robust system to ensure all staff records are updated when they have read updates to current guidance and policies.

Bucks & Oxon Divisional HQ – South Central Ambulance Service

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** The team included a second CQC inspector, GP specialist advisor, and two additional clinical specialist advisors with experience of working in and managing NHS 111 and GP out of hours services.

Background to Bucks & Oxon Divisional HQ – South Central Ambulance Service

South Central Ambulance Service (SCAS) NHS Foundation Trust was established on 1 July 2006 following the merger of four ambulance trusts. On 1 March 2012 they became a foundation trust.

The trust's three main functions are:

•The provision of A&E service to respond to 999 calls.

•The NHS 111 service for when medical help is needed fast but it's not a 999 emergency.

•The Patient Transport Service.

The NHS 111 service was the only part of SCAS inspected at this focused inspection.

The South Central Ambulance Service (SCAS) NHS Foundation Trust service employ 400 NHS 111 staff (200 whole time equivalent); their emergency operation centres handle around 1 million calls each year.

The provider operate NHS 111 services from two locations: Bicester in Oxfordshire and Otterbourne in Hampshire. The provision of service covers the counties of Hampshire, Berkshire, Bedfordshire, Oxfordshire and Buckinghamshire. The area covered has a geographic area of 4,600 square miles and a population of 4.6 million. There are 21 Clinical Commissioning Groups (CCGs) within the area, 836 GP surgeries, 568 dental practices and 791 pharmacies. The area covered contains a mixture of urban areas of high density population such as Portsmouth, Southampton, Reading, Slough, Oxford and Milton Keynes, and large areas of rurality such as the New Forest, North Hampshire, West Oxfordshire and parts of Buckinghamshire.

The provider's governance structure identifies links with seven CCGs: Bedfordshire, Berkshire, Aylesbury Vale, Chiltern CCG, Hampshire, Luton and Oxfordshire.

The SCAS NHS Foundation Trust NHS 111 service operates 24 hours a day 365 days of the year. It is a telephone based service where patients are assessed, given advice and directed to a local service that most appropriately meets their needs. For example, this could be an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance or late opening chemist.

Detailed findings

Why we carried out this inspection

The focused inspection under Section 60 of the Health and Social Care Act 2008 was in response to concerns received by an undercover media reporter. The purpose was to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. The inspection looked at specific areas of the service under the Care Act 2014.

The NHS 111 service had been inspected previously in August 2013, as part of a pilot to test new CQC methodology.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the provider and asked other organisations to share what they knew. We carried out an announced visit on 11 and 12 November 2015. During our visit we:

- Spoke with a range of staff including 11 senior managers and 15 operational staff across both locations.
- Observed how calls were managed and referred to other providers
- Reviewed records, data and policies used at the service.

To get to the heart of patients' experiences of care and treatment, we asked four questions:

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

We did not look at whether the service was caring as that was not required for the focused inspection.

At this inspection we did not consult with patients or look at survey results as the concerns we received did not relate to patient dissatisfaction.

Are services safe?

Our findings

Concerns made by an undercover reporter alleged that there were unsuitable levels of staffing and inadequate staff recruitment processes in place. There were also concerns raised about significant events management and the staff involvement in this process.

At this inspection we looked at staff recruitment processes, staffing levels, staff training, staff support, and significant events management.

The provider had taken prompt and appropriate action following the allegations.

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they were aware of how to escalate incidents, concerns and events and that this process had been improved through additional training and use of electronic systems which had made the process more streamlined. Staff had access to the recording form available on the provider's computer system.
- Staff told us the culture of reporting concerns had improved since the media comments had been received and that they felt able to report concerns freely without fear of reprisals.
- The provider carried out a thorough analysis of the significant events. Monthly 'end to end' meetings were held where significant events and complaints were discussed with internal staff and external stakeholders, for example, ambulance service, out of hours providers, clinical commissioning groups and staff from South Central Ambulance Service Foundation Trust (SCAS). Where appropriate the provider linked with the coroner to see if any learning could be identified following an unexpected death. Families were involved in this process as little or as much as they wanted to be, and they were kept up to date at each step of the process. Information from complaints, significant events and learning was cascaded to all staff by email, a monthly newsletter and team briefing notices. We saw evidence of learning from events. For example, the undercover reporter had raised concens about the recruitment processes. Whilst no major issues were raised it was noted that photocopied documents had been accepted. The provider had introduced systems to ensure that only original documents would be accepted.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the service. For example, the adverse coverage of concerns by the media had resulted in immediate communication with CQC, CCGs and NHS England. An investigation was performed by the patient safety directorate and was independently monitored. The investigation had highlighted four elements which had then been systematically investigated. These included human resources (staff recruitment), clinical governance, NHS Pathways and leadership and culture. For example, during the investigation it was noted that supervision and coaching of staff could be improved. Changes to the coaching programme had resulted in increased staff supervision and support. These changes had been reported to external stakeholders who were overseeing the investigation.

Every patient or patient's relative who had been affected had been contacted by telephone and given details of the complaints procedure and details of the patient experience team to offer ongoing support if required.

Overview of safety systems and processes

Following the concerns raised during the adverse media coverage the recruitment processes had been reviewed. No major concerns had been identified and one minor issue about a photocopied document had been addressed.

- We reviewed ten personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We saw that agency staff recruitment processes had been followed appropriately.

Monitoring risks to patients

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were

Are services safe?

on duty. Staff told us that there were additional staff scheduled for peak times of the day and expected busy periods such as national holidays although this was sometimes a problem during staff sickness or unexplained busy times. Records confirmed that agency staff were used to provide cover for these times. Records showed that agency call handlers received the same training, the same level of support and had the same programme of audit as substantive staff and had the same performance criteria applied to them.

During the investigation process which commenced in June 2015 Quality Assurance Coaches (QAC) had been introduced. Staff told us that since they had been introduced they felt more supported and were able to access senior members of staff to get acute answers to questions about the NHS Pathway of care, including transfers to the 999 service. The QACs were also able to listen to calls, intervene or alert clinical shift managers (CSMs) and clinicians if there was a problem or should they need assistance for ambulance transfers and requests.

Arrangements to deal with emergencies and major incidents

The provider had adequate arrangements in place to respond to emergencies and major incidents. Staff were aware of the NHS Pathway to be used if patients called with life threating conditions such as heart attack, diabetic emergencies, suicide, fits and unconsciousness.

The provider had operational systems in place to escalate major incidents and incidents which required national emergency response and processes to involve other emergency staff. All staff had received first aid training and had access to emergency equipment including defibrillators and fire safety equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Concerns made by an undercover reporter alleged that there were ineffective staff training, lack of staff support and inappropriate use of systems and processes. For example unnecessary referrals to the 999 service and inappropriate responses by call handlers.

At this inspection we looked at the telephone and computer systems used, response times of call handlers, records kept of patient responses and data related to call handling and management. We also looked at staff training records, staff support and supervision processes.

Effective needs assessment

Calls were triaged through NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). Staff told us the NHS Pathways were updated regularly and changes communicated to staff through training sessions and formal communication. Staff were subject to audits to ensure effective compliance to prioritise and categorise calls according to the clinical needs of patients.

Clinical staff were aware of and used current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

The provider had systems in place to keep all staff up to date through regular coaching, staff training programmes, monthly newsletters and regular review of policies and standard operating procedures (SOP). The staff had access to a 'hotbox' that contained updated information including NHS Pathways changes and policy updates. Staff were required to sign and demonstrate they had read the article. The checking of this was sporadic and not routine.

The provider monitored that guidelines were being followed by staff by randomly auditing patient calls. Call handlers said they had been told of this process during their induction and probationary period. New staff told us they had a minimum of six of their calls audited each month and existing staff told us they had five audits a month, this was in line with the policies we reviewed. Records confirmed that the audit included competency effective call control, skilled questioning, active listening, skilled provision of information and advice, effective communication, practices according to designated role requirements, skilled use of NHS Pathways functionality, and delivering a safe and effective outcome for the patient.

Management, monitoring and improving outcomes for people

Call handlers were closely monitored on transfer rates to a clinician and to 999 services. Team leaders worked on the floor with quality assurance coaches (QAC). The QAC role had been budgeted and planned prior to the investigation and findings. The QAC's were recruited, trained and rolled out during the time of the investigation process. The team leaders and QACs were protected from operational pressures in order that they could assist and support Call Handlers in their decision making.

We observed that call handlers were able to ask for assistance when they were unsure of the correct answer in the NHS Pathways or the correct symptom to prioritise for assessment. We noted that call handlers were supported to make the correct decision. Staff explained this allowed learning to take place, rather than passing the call to someone else to deal with. Feedback from call handlers about this change was very positive as they felt empowered to ask for assistance to deal with complex situations and considered the process as a way of learning from the experience and preparing them to deal with situations more effectively in the future.

Calls where assistance was requested from the call handlers was recorded on a spreadsheet and on the specific event; these calls were monitored by the clinical assurance team through audit and assisted in informing future training and monthly staff updates/assessments. Quality Assurance Coaches also spent time sitting side by side with call handlers and provided real time feedback and coaching to ensure the quality of assessment and outcome met the clinical need of the caller.

Clinical assurance quality audits took place on all staff working in the NHS 111 services in line with the National NHS Pathways License to ensure that calls were clinically safe and effective. The Trust explained that in the previous six months a total of 10,649 random call audits had been completed and explained that the non-compliance rate was currently 11% which compared well to the national average non-compliance rate of 20% in call audit. These competencies included the NHS Pathways system

concepts, structure and call process. They also included assessments of clinical decision making, care advice and communication skills – listening, questioning, interpreting and evaluating information.

All staff received face to face feedback on all call audits. Any non-compliant audits highlighted had an action plan for staff to complete. Supportive documentation was provided including reflective practice templates, guidance notes and hot topics. Where trends were recognised training throughout the organisation was reinforced for new staff and also included in the monthly Continuous Professional Development workbooks that were distributed to all staff.

The provider used national data to monitor performance and outcomes for patients. For example, data from the national situational report (SITREP) in November showed that:

- Call transfers between August 2015 and October 2015 from 111 to 999 was between 8.90% and 10.22% which was lower than the national average of 11.4%
- Abandoned 111 calls between August 2015 and October 2015 was reported between 0.50% and 0.78% which was lower than the national average of 1.5%
- Transfer of 111 calls to clinicians between August 2015 and October 2015 ranged between 18.0% and 18.50% which was lower than the national average of 22.6%
- Calls answered within 60 seconds were reported at an average of 94% which was higher than the national average of 90.7%

This data was monitored on a four hourly frequency by operational staff. The executive management committee then reviewed this data every two weeks to monitor patient safety and experience.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The provider had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Although the media concerns had not highlighted significant cause for concern the provider had changed the induction programme. For example, the initial training had increased from three weeks to four weeks. There had been an introduction of quality assurance coaches (QACs) to support new and existing staff and the performance of staff was also audited more frequently to monitor the effectiveness of staff.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff through the use of a comprehensive training matrix which worked alongside IT systems which identified in advance when staff were due refresher training.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of provider development needs. This also included any themes identified through the analysis of complaints and significant events.
- Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, appraisals, coaching and mentoring. Staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.
- Following the allegations and subsequent investigation the provider had facilitated additional training on subjects including leadership styles, culture, 111 team values and additional coaching for all staff.

Coordinating patient care and information sharing

The details of calls into the 111 service information were shared in an appropriate, secure and timely way to the appropriate care provider.

- For example, a patient who was advised to see their GP within two hours had a summary of the call automatically generated at the end of the call. This was then sent to the patient's GP and enabled the GP to have information regarding the call prior to seeing the patient. This communication also occurred to the out of hours provider and some acute trusts. The information shared the concerns raised initially by the patient and the following assessment undertaken using the pathways tool by the 111 service.
- Staff had access to information shared by GP practices and other health care professionals. For example, the

Are services effective?

(for example, treatment is effective)

computer system had pop up boxes to alert call handlers to information. For example, where a patient is a vulnerable adult or if they have a care plan or end of life care plan in place.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Call handlers were instructed to transfer calls where a patient's capacity was in question to clinical staff.
- Where a patient's mental capacity to consent to care or treatment was unclear the process for seeking consent was monitored through audits. This ensured consent records met the provider's responsibilities within legislation and followed relevant national guidance.
- The consent was integrated in the patient pathway. Patients were asked if they allowed the information about the call to be passed to their GP.

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Are services caring?

Our findings

We did not look at whether the service was caring as that was not required for the focused inspection. Other patient outcomes are included within other areas of the report.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider reviewed the needs of its local population and had systems to support staff in providing an effective service. For example, the provider offered a service to temporary residents, patients on the move and covered military bases, prisons and atomic weapons establishments. The provider had provided staff with guidance on how to efficiently identify where patients were located. There were language interpretation services available to communicate with patients whose first language was not English.

Access to the service

The service was open 24 hours a day, seven days a week and 365 days a year.

Listening and learning from concerns and complaints

Allegations made by an undercover reporter in July 2015 had raised concerns over the management of complaints.

At this inspection we looked at how complaints were managed, monitored and used to drive improvement. We saw that the provider had taken prompt and appropriate action in response to the concerns received.

We found that the provider had an effective system in place for handling complaints and concerns.

- Their complaints policy and procedures were in line with recognised guidance and met contractual obligations. Information on how to complain was located on the provider website and on the NHS Choices website.
- There was a designated process and department where all complaints were handled and escalated if appropriate.

The service had received 91 complaints between October 2014 and September 2015 and records showed that these had been handled in a satisfactory and timely way with patients being consulted about actions taken and any outcomes. The provider exercised a duty of candour and where things went wrong we saw patients had been kept informed and had received an apology. There was a culture of using complaints as a way of improving service provision. Systems were in place to monitor outcomes from investigations. An overview of complaints was maintained to monitor any trends in complaints received. For example, any trends identified were used as a theme for the month and staff were then provided with additional information and training. The provider worked with external organisations appropriately and openly. For example, as a result of the media allegations the provider had consulted and worked with NHS England and clinical commissioning groups to ensure transparency throughout the process.

Are services well-led?

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

Our findings

Concerns in the media made by an undercover reporter alleged that governance arrangements, leadership and opportunities for staff feedback was inadequate.

At this inspection we looked at leadership and management styles, governance arrangements, and opportunities of how staff could provide feedback.

Vision and strategy

The provider had a clear vision and set of team values to deliver high quality care and promote good outcomes for patients. The vision and values were communicated through the staff induction, on the provider website and contained in the monthly staff newsletter. Staff we spoke with were aware of the vision and understood their own responsibilities in relation to this.

The provider had a robust strategy and supporting business plans which reflected the vision and values of the organisation. These had been reviewed since the investigation and had resulted in the core values being embedded in the training materials.

Governance arrangements

The provider had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Service specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the service
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

There had been a change of management within the call centres and introduction of quality assurance coaches and an increase of coaching and supervision. The senior management team demonstrated they had reviewed the organisational structure to show they had the experience, capacity and capability to run the service and ensure high quality care. Staff explained the managers were visible and supportive. Staff told us morale had improved in recent months. They spoke respectfully and highly of their immediate line managers and of the senior management team. Staff added that there had been a change in culture with an improvement in openness and the support offered.

The provider was aware of and complied with the requirements of the Duty of Candour. Senior leaders encouraged a culture of openness and honesty. The provider had systems in place for reporting notifiable safety incidents. Staff said that improvements had meant that they were provided with time to report incidents and concerns and said the process was easier and more efficient since the media interest.

The provider gave patients and staff affected by the investigation reasonable support and truthful information. For example, following receipt of the adverse media information the provider had made contact with all patients involved and offered them support and information. Staff were also offered additional support through occupational health, and the employee assistance programme.

There was a clear leadership structure in place and staff felt supported by management.

A meeting structure was in place for senior managers and this information was cascaded to all staff by email, a monthly newsletter and team briefing notices. For example, we saw the provider had introduced a document named SCASCADE which communicated learning through case histories, significant events and complaints. Staff we spoke with confirmed that communication within the organisation had improved.

Seeking and acting on feedback from staff

Staff spoke of an attitude of wanting to learn from recent events and openness to suggestions and feedback. When challenged with complex issues or concerns staff were confident that they would be supported by their managers.

The provider used complaints from patients to identify trends and areas for learning and development. The

Are services well-led?

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

provider had also received 106 compliments in the last year and had kept records of these. These were communicated to staff within the monthly staff newsletter. Staff told us these were encouraging.

The provider encouraged and valued feedback from patients, the public and staff.

- The service had gathered feedback from staff through a twice yearly in house survey called 'friends and family', through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.
- Everyone got the opportunity to make suggestions and put forward their ideas and suggestions. The response rate from the friends and family survey was the highest of all trusts nationwide in 2014. The results received were broken down into the relevant services and the results were then shared with managers who in turn fed back to their staff. Actions were put in place as a result. For example, within the building there were 'pledges' boards and suggestion boxes. These were where staff could make suggestions for improvements, for example a team building day.
- Improvements were made as a result of suggestions by staff. For example, the forms used for safeguarding referrals were streamlined to be more 111 specific and safeguarding training was delivered in a more modular way, in smaller batches so that part time staff were able to complete this more easily.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the service. The provider had used the investigation to review and to improve practice. For example, the provider stated that of the specific issues raised by the newspaper, none had been substantiated to give a significant cause for concern over the safety of the service that the Trust provided. These judgements were externally reviewed monthly by the Commissioning Clinical Governance GP leads. However, the Trust acknowledged that other issues had been identified during the course of the investigation which did give cause for concern and had resulted in changes and improvements being made.