Brocklebank Health Centre

Quality Report

249 Garratt Lane
London
SW18 4UE

Website: www.seldoc.co.uk

Date of inspection visit: 5 September 2017
Date of publication: 23/10/2017

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the SELDOC Out of Hours Service at Brocklebank Health Centre on 5 September 2017. Overall the service is rated as good.

Our key findings across all the areas we inspected were as follows:

- The arrangements for managing medicines at the service did not always keep patients safe. Medicines audits had been introduced but were not yet completed, with one cycle being carried out and as such did not demonstrate actions identified had been implemented or were effective in making improvements in prescribing and medicines management. The provider did not record the dispensing of medicines in line with guidelines.
- The service did not carry medical gases such as Oxygen, or an Automatic External Defibrillator (AED) in vehicles used for home visits and did not have a documented risk assessment mitigating their absence.
- There were clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse.
- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Patients' care needs were assessed and delivered in line with current evidence based guidance and in a timely way according to need. The service met the relevant National Quality Requirements.
- Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There was a system in place that enabled staff access to patient records, and the out of hours staff provided other services, for example the local GPs and hospital, with information following contact with patients as was appropriate.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

Summary of findings

- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The area where the provider must make improvement is:

- Develop effective systems and processes to ensure safe care and treatment including ensuring the proper and safe management of medicines, and assessing the risk of not providing Oxygen and Automatic External Defibrillator on service vehicles used for home visits and, where appropriate, mitigate their absence.

The area where the provider should make improvement is:

- Ensure that risk assessments undertaken by the building owner are available to the provider.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The service is rated as requires improvement for providing safe services.

- The arrangements for managing medicines at the service did not always keep patients safe. Medicines audits had been introduced but were not yet completed, with one cycle being carried out and as such did not demonstrate actions identified had been implemented or were effective in making improvements in prescribing and medicines management. The provider did not record the dispensing of medicines in line with guidelines.
- The service did not carry medical gases such as Oxygen, or an Automatic External Defibrillator (AED) in vehicles used for home visits and did not have a documented risk assessment mitigating their absence.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective system in place for recording, reporting and learning from significant events
- Lessons were shared to make sure action was taken to improve safety in the service.
- When things went wrong patients were informed in keeping with the Duty of Candour.They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the event in the preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- The out-of-hours service had clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse.
- The service did not have access to all of the premise risk assessments carried out by the owner of the premises.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients if required.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

Are services effective?

Good

The service is rated as good for providing effective services.

- The service was consistently meeting National Quality Requirements (performance standards) for GP out of hours services to ensure patient needs were met in a timely way.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits of GP performance against standards and guidelines demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from patients through our comment cards and collected by the provider was positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- Service staff reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The service is rated as good for being well-led.

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The service had identified and responded to concerns raised around monitoring and prescribing of medicines in the service; however improvements had not yet been fully implemented and their effectiveness assessed.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The service proactively sought feedback from staff and patients, which it acted on.

Summary of findings

What people who use the service say

As part of our inspection we asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received six completed comment cards from patients which were wholly positive about the service experienced. Patients commented that the service was good, efficient and that staff were helpful including doctors and reception staff.

Brocklebank Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector, and a service manager specialist adviser.

Background to Brocklebank Health Centre

South East Doctors Cooperative Limited (SELDOC, the provider) is commissioned to provide a range of GP out of hours services in south London. In South West London, Brocklebank Health Centre is one of seven hubs at which patients may attend. There is a single hub that has administrative oversight for the area. Governance arrangements are co-ordinated locally by service managers and senior clinicians for each of the ten service locations, including the service provided from Cricket Green Medical Centre.

The service has a double size consulting room that may be split into two, a reception area and storage at 249 Garratt Lane, London, SW18 4UE. During the day the premises are used by a GP service which is managed by a separate provider. The service is on one level and is accessible to those with restricted mobility.

The service is open between 6:30pm and 10pm Monday to Friday, on Saturdays and Bank Holidays from 8am until 10pm and on Sundays from 9am until 1pm. Patients can only attend the service with referral through the NHS 111 service. The service sees approximately three patients per hour on average during the week and four patients per hour at weekends.

The service is led by a service manager (who is based at SELDOC's headquarters), and there is a GP on site who has oversight of the out of hours service. Team Leaders are also available via telephone at the service headquarters to address any problems staff may face.

GPs working at the service are either bank staff (those who are retained on a list of employed staff by the provider and who work across all of their sites) or agency. The site has permanently employed part time reception staff.

The service is registered with the Care Quality Commission (CQC) for the regulated activities of treatment of disease, disorder or injury, and transport services, triage and medical advice provided remotely.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 5 September 2017. During our visit we:

Detailed findings

- Visited the provider headquarters before visiting the service location.
- Spoke with a range of staff (including directors of SELDOC, service managers, GPs, administrators and receptionists) and spoke with patients who used the service.
- Observed how patients were provided with care.
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage risks to staff and service users.
- Looked at the vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the service manager of any incidents and there was a recording form available on the service computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- The service carried out a thorough analysis of the significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes.
- The SELDOC service had a weekly bulletin and monthly newsletter that was sent to GPs working in the service that informed them of any learning from serious incidents.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services in place in some areas to keep patients safe and safeguarded from abuse. Examples included:

- The service had protocols and policies in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a safeguarding referral system in place including a referral form on the service computer system. There was a lead member of staff and deputy for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The Medical director and Deputy Medical Director had received training to level 5, GPs were trained to child safeguarding level 3, and non-clinical staff were trained to level 1. Referrals were made where required.
- A notice in the waiting room and in the consulting rooms advised patients that chaperones were available if required. All 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).
- The service maintained appropriate standards of cleanliness and hygiene. We observed the areas in the building used by the service to be clean and tidy. There was an infection control protocol in place and staff had received up to date training. There was an infection control lead, although the primary responsibility for infection control on site was the GP practice provider whose rooms were being used by the service. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance, for example calibration of diagnostic equipment.
- We reviewed nine personnel files for staff working across the service, including at this location, and found appropriate recruitment checks had been undertaken prior to employment, including for bank and agency staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines did not always keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).

Requires improvement

Are services safe?

- The provider had a range of appropriate policies, procedures and guidance accessible by staff. These were regularly reviewed and met local and national guidance.
- At this inspection we found the service had carried out recent medicines audits between January and March 2017 for the whole service to ensure prescribing was in accordance with best practice guidelines for safe prescribing. These audits were not completed, with one cycle being carried out, and as such did not demonstrate actions identified had been implemented or were effective in making improvements in prescribing and medicines management. Managers told us that the one audit that had been completed was inacurrate and they had therefore had to repeat the first audit. We did see examples of individual GP's who had been contacted for feedback on their own high prescribing rates and were reminded of the service prescribing policies and procedures.
- Blank prescription forms were securely stored in the out of hours service and there were systems in place to monitor their use.
- The service did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) however the provider did have standard operating procedures in place that set out how controlled drugs were prescribed and managed in accordance with the law and NHS England regulations.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles. Medicines were kept in cassettes which were sealed at the point of packaging. Cassettes were delivered to and collected from sites on a regular basis and as required. Cassettes carried an appropriate range of medicines based on the needs of patients using the service. Managers at the service told us that they were in the process of evaluating how medicines were managed and were considering outsourcing this to another company. Additional medicines were accessed through local pharmacies by patients if required. The service did not have an appropriate system for recording and auditing medicines dispensed from cassettes on home visits or from out of hours locations. The service recorded if medicines were dispensed on a check sheet that stayed with the cassette rather than by purple prescription as is required. The provider had recently reviewed this system and had procured the necessary prescriptions forms but had not yet implemented training and delivery of the improved system.
- Arrangements were in place to ensure medicines carried in the out of hours vehicles were stored appropriately. Vehicles used by the service did not carry medical gases such as Oxygen, or an Automatic External Defibrillator (AED) and did not have a documented risk assessment mitigating their absence.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The service manager, told us that risk assessments such as those for fire risk had been carried out by the owner of the building, but that they had not provided copies of these.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. The site operators had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings) which the service were involved in.
- There were systems in place to ensure the safety of the out of hours vehicles operated from the provider headquarters. The service used a comprehensive checklist which was undertaken by the driver at the beginning of each shift. Records were kept of MOT and servicing requirements. We checked the vehicles and found that they were clean, tidy and were in good working condition.
- 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 enough staff were on duty. The inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand.

Requires improvement

Are services safe?

- National Quality Requirement (NQR) 7 states that the provider must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand. The service had thorough documented policies and staffing levels were reviewed monthly, and escalation policies were in place if required.

Arrangements to deal with emergencies and major incidents

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

- There was an effective system to alert staff to any emergency.
- All staff received annual basic life support training, including use of an automated external defibrillator.
- The site had a defibrillator and oxygen with adult and children's masks available on the premises.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for key staff and contractors.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best service guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- There was a clinical assessment protocol and staff were aware the process and procedures to follow. Reception staff had a process for prioritising patients with any presenting high risk symptoms.

Management, monitoring and improving outcomes for people

From 1 January 2005, all providers of out-of-hours services have been required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group on their performance against standards which includes audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

Performance between October 2016 and June 2017 showed the following:

- The service undertook a monthly review of one per cent of patient contacts in line with National Quality Requirement (NQR) 4.
- NQR 10 requires that providers start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre with a target of 100%. This target had been met in each of the last nine months since the provider started to operate the service. NQR 10 also requires that the service start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre with a target of 100%. This target had been met in each of the last nine months.
- NQR 12 requires that face-to-face consultations (whether in a centre or in the patient's place of residence) of emergency patients must be started within one hour (with a target time of 95%), after the definitive clinical assessment has been completed. In each of the last nine months the service had achieved 100%. It also requires that face-to-face consultations (whether in a centre or in the patient's place of residence) of urgent patients must be started within two hours (with a target time of 95%), after the definitive clinical assessment has been completed. In the last nine months the service had achieved between 96% and 100%. Finally, NQR 12 requires that face-to-face consultations (whether in a centre or in the patient's place of residence) of less urgent patients must be started within six hours (with a target of 95%), after the definitive clinical assessment has been completed. In the last nine months the service had achieved between 96% and 100%.

We saw evidence of daily performance monitoring undertaken by the service including a day by day analysis and commentary. This ensured a comprehensive understanding of the performance of the service was maintained.

There was evidence of quality monitoring and improvement through clinical audit;

- A review of 1% of clinical consultations. This included all clinicians being audited within one month of them commencing work with the service, and an ongoing monthly audit of GP consultations. Consultation audits included face to face consultations and telephone consultations. GPs receive quarterly audit score feedback and we saw evidence that where standards fall below the 80% pass mark, the GP's performance was managed in line with the providers policy.
- The service participated in local prescribing audits and national benchmarking.
- Staff told us that feedback would be provided via email, telephone call, in one to one sessions or performance review meetings, but if there were wider areas for learning these would be shared with the whole team through email bulletins and newsletters.

Effective staffing

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

Good

Are services effective?

(for example, treatment is effective)

- The service had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Mandatory training requirements for all staff were monitored centrally, with clinicians not being selected for clinical shifts if their mandatory training was not up to date and we saw examples of this system working.
- Staff involved in handling medicines received training appropriate to their role.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- This included access to required special notes which detailed information provided by the person's GP. This helped the out of hours staff in understanding a person's needs.
- The service shared relevant information with other services in a timely way, for example by sending out-of-hours notes to the registered GP services electronically by 8am the next morning.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients using the out of hours service.
- The provider worked collaboratively with other services.
- Patients who could be more appropriately seen by their registered GP or an emergency department were referred.
- If patients needed specialist care, the out-of-hours service, could refer to specialties within the hospital.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was sufficient room in the GP practice to ensure that this could happen.

The six patient Care Quality Commission comment cards we received specific to this location were positive about the service experienced. Patients commented that the service was good, efficient and that staff were helpful including doctors and reception staff. They also commented that the location at which the service was based was clean and modern.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they 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. Patient feedback from the comment cards we received was also positive and aligned with these views.

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available to be printed in easy read format and in a range of languages.
- The service had access to a hearing loop if required.
- Information was available for patients regarding who to contact in the event that symptoms persisted.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There were no patients registered at the service as it was designed to meet the needs of patients who were consulting a general practitioner when their own GP practice was closed.

The premises were shared with a GP surgery which used the areas utilised by the out of hours service during weekdays before 6:30pm. The waiting area for patients was a large and brightly decorated room adjacent to the reception area. This meant that reception staff could always see patients who were waiting, and could act if a patient became acutely unwell.

The service reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.

- Appointments were not always restricted to a specific timeframe so clinicians were able to see patients for their concerns as long as necessary if the presenting condition was complex. The receptionist could also alter appointments if required.
- All areas to the service were accessible to patients with restricted mobility.
- The waiting area for the service was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms. There was enough seating for the number of patients who attended on the day of the inspection.
- Toilets were available for patients attending the service, including accessible facilities with baby changing equipment.

Access to the service

The service was open between 6:30pm and 10pm Monday to Friday, on Saturdays and Bank Holidays from 8am until 10pm and on Sundays from 9am until 1pm. Patients could only attend the service with referral through the NHS 111 service.. The out of hours service was available for registered patients from all general practices within the local clinical commissioning group area.

Feedback received from patients from the Care Quality Commission comment cards and from the National Quality Requirements scores indicated that patients were seen in a timely way.

The service had a system in place to assess:

- whether a home visit was clinically necessary; and
- The urgency of the need for medical attention.

This was achieved by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for urgent care centres and out of hours services in England.
- There was a designated responsible person who handled all complaints in the service.
- We saw that information was available to help patients understand the complaints system through information in the waiting areas.

We looked at seven complaints received in the last nine months, since the provider was registered with the CQC. We saw that in all cases patients received a written response, with details of the Parliamentary Health Service Ombudsman's office provided in case the complaint was not managed to the satisfaction of the patient. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The service had a mission statement and staff knew and understood the values.
- The service had a robust strategy and supporting business plans that reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff, although those relating to medicines management were not consistently in line with guidelines.
- The provider had a good understanding of their performance against National Quality Requirements. These were discussed at senior management and board level.
- Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements, and the service had identified and responded to concerns raised around monitoring and prescribing of medicines in the service; however improvements had not yet been fully implemented and their effectiveness assessed.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the provider demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us that there were clear lines of responsibility and communication. Staff told us that senior managers were approachable although they did not work in the same premises as those at which the service was based. Reception staff told us that team leaders were always available on the telephone for checking in at the start and end of shift and for managing queries and issues that may arise.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment:

- The service gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

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

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included newsletters and e-mails from senior staff at the organisation.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, the public and staff

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

- Patients were provided with an opportunity to provide feedback, and if necessary complain.

Are services well-led?

Good

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

- Staff told us that 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.
- Staff told us that they were proud of the service being delivered and that they felt engaged in decisions relevant to how the service might be delivered in the future.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for service users; • The provider did not ensure the proper and safe management of medicines. • The provider did not assess the risk of not providing Oxygen and Automatic External Defibrillator on service vehicles used for home visits or mitigate their absence. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.