South East London Doctors Cooperative Limited (SELDOC) Out-of-Hours Service at University Hospital Lewisham Urgent Care Centre

Quality Report

University Hospital Lewisham
Lewisham High Street
London
SE13 6LH
Tel: 0208 693 9066
Website: www.seldoc.co.uk

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

Ratings

Overall rating for this service	Requires improvement
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?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at South East London Doctors Cooperative Limited (SELDOC) Out-of-Hours (OOH) Service based at University Hospital Lewisham Urgent Care Centre on 24 February 2017. Overall the service is rated as requires improvement.

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

- The provider had an open and transparent approach to safety and a system in place for recording, reporting and learning from significant events and staff understood their responsibilities to raise concerns and report incidents and near misses. However, the location had not reported any incidents in the last 12 months.
- There were systems and processes in place to keep patients safe and safeguarded from abuse at an organisational level but no safeguarding referrals had been made in the last 12 months from the Lewisham location. This is not in line with a service of this type and size. Furthermore, the provider could not demonstrate that all GPs had completed safeguarding children and adult training or that the hospital trust staff undertaking chaperoning were trained and had received a Disclosure and Barring Service (DBS) check.
- The provider had processes and systems in place at an organisational level for the dissemination of NICE guidance, patient safety alerts and organisational and policy changes but could not demonstrate how it ensured the GPs working at the location consistently received these and that appropriate action was taken.
- Patients' care needs were assessed and delivered in a timely way according to need. The service met the National Quality Requirements.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The service managed patients' care and treatment in a timely way.

Summary of findings

- 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.
- The service operated within a hospital trust 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 areas where the provider must make improvements are:

- Ensure all staff are up-to-date with safeguarding children and adult training.
- Ensure that hospital trust staff undertaking chaperoning are trained and have received a Disclosure and Barring Service (DBS) check.
- Develop an effective system for sharing patient safety alerts and national guidance.
- Implement a process to keep staff at the location aware of local systems, protocols and policy changes.

The areas where the provider should make improvements are:

- Review how patient feedback is collected for each location and consider analysing data separately to ensure any findings and trends relevant to a specific location are being addressed.
- Review the privacy and dignity during examinations, investigations and treatment arrangements for patients.

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.

- There was a system in place for recording, reporting and learning from significant events and staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses. However, the location had not reported any in the past 12 months.
- When things went wrong patients were informed in keeping with 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).
- The provider had an organisational process and system in place for a cting upon patient safety alerts but could not demonstrate how it ensured GPs working at the location consistently received these and that appropriate action was taken.
- There were systems and processes in place to keep patients safe and safeguarded from abuse. 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. However, no safeguarding referrals had been made in the last 12 months. It is unlikely that a service of this size and type would not have needed to make a safeguarding referral. Furthermore, the provider could not evidence that all GPs working at the location had completed safeguarding children and adult training.
- The provider could not demonstrate that hospital trust staff providing a chaperone service to its patients 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 provider had oversight of the health and safety arrangements in relation to the location utilised at the hospital trust.

Are services effective?

Good

The service is rated as good for providing effective services.

Summary of findings

- The provider had an organisational process and system in place to keep all clinical staff up-to-date with NICE guidance but could not demonstrate how it ensured staff at the location had access to these consistently.
- Data showed that the service for the most part met National Quality Requirements (performance standards) for GP out of hours services to ensure patient needs were met in a timely way.
- There was a programme of clinical audits which included at least one monthly audit.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of personal development plans and performance review of all clinicians.
- 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 all patients through our comment cards was very 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 operated from a hospital trust 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.

Summary of findings

- 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.

Are services well-led?

Requires improvement

The service is rated as requires improvement 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.
- Although the organisation had an overarching governance framework that supported the delivery of the vision and good quality care their was a lack of monitoring and oversight at the Lewisham location.
- 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.
- 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 proactively sought feedback from patients, but could not provide outcome data solely for the Lewisham location. The provider engaged in patient and public events which had included participation at health fairs in the local community.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the out-of hours service they received. Patient feedback was obtained by the provider on an ongoing basis and included in their contract monitoring reports. Although we reviewed the data we were unable to ascertain which feedback related to the Lewisham location as outcome data for all the provider's south east London locations in the boroughs of Lewisham, Southwark and Lambeth were amalgamated.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards which were all positive about the standard of care received. Patients said they felt the service offered a good, prompt and efficient service and staff were helpful, caring and treated them with dignity and respect.

We were unable to speak to any patients during inspection.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff are up-to-date with safeguarding children and adult training.
- Ensure that hospital trust staff undertaking chaperoning are trained and have received a Disclosure and Barring Service (DBS) check.
- Develop an effective system for sharing patient safety alerts and national guidance.
- Implement a process to keep staff at the location aware of local systems, protocols and policy changes.

Action the service SHOULD take to improve

- Review how patient feedback is collected for each location and consider analysing data separately to ensure any findings and trends relevant to a specific location are being addressed.
- Review the privacy and dignity during examinations, investigations and treatment arrangements for patients.

South East London Doctors Cooperative Limited (SELDOC) Out-of-Hours Service at University Hospital Lewisham Urgent Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team also included a GP specialist adviser.

Background to South East London Doctors Cooperative Limited (SELDOC) Out-of-Hours Service at University Hospital Lewisham Urgent Care Centre

South East London Doctors Cooperative Limited (SELDOC) is a doctors' cooperative established in 1996 and owned by its 120 member surgeries. SELDOC provides out-of-hours (OOH) primary medical services to just over a million patients in the four south east London locations in the boroughs of Lewisham, Southwark and Lambeth of which 324,000 are in Lewisham. The out-of-hours provision provided at each of the SELDOC south east London locations was commissioned as one contract. However, the provider had registered each of the locations separately with the Care Quality Commission (CQC).

The SELDOC OOH service at Lewisham operates from one consulting room located in the Urgent Care Centre at University Hospital Lewisham, Lewisham High Street, London, SE13 6LH. The consulting room is used by the hospital trust when the OOH service is not operating. The OOH service is delivered by one SELDOC GP at each session. There are no other SELDOC staff at the location. The service utilises the hospital trust's reception team in the Urgent Care Centre. Call handling and appointment booking for the service is undertaken at SELDOC's administration base at Dulwich Community Hospital. A service manager provides oversight of the service and there is also a duty doctor available by telephone to provide support during the OOH sessions provided at Lewisham. We visited the Dulwich location to speak with management

and administration staff who delivered the service at Lewisham but we did not inspect this location. The Dulwich location was inspected by the Care Quality Commission on 20 January 2015 was rated as good.

The service operating from the Lewisham location is GP-led and appointment only on Monday to Friday from 8pm to midnight and at weekends and bank holidays from 10 am to 10pm. The service from this location does not provide consultations in patients' homes so there were no vehicles allocated to this location.

The provider is registered with the Care Quality Commission (CQC) for the regulated activities 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 24 February 2017. During our visit we:

- Spoke with a range of staff at the South East London Doctors Cooperative Limited (SELDOC) administration base at Dulwich Community Hospital who were responsible for the centralised management and governance of the organisation. These included the medical director, director of operations, HR manager, health and safety manager, clinical governance manager and pharmacy adviser. We also spoke with the duty doctor at the Lewisham location during the time the OOH service was operating.
- Observed how patients were provided with care.
- Inspected the out-of-hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- 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 a system in place for reporting and recording significant events.

- There was a paper copy of the incident and serious incident reporting policy available at the Lewisham location detailing what constituted a significant event and how to report it. The policy included an incident recording form which 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). The provider told us that policies and procedures at the Lewisham location were only available in paper copy as the hospital trust IT system did not support the SELDOC intranet which was the organisation's portal to store all policies and procedures. We reviewed paper documentation at the Lewisham location and found the policy to be available and in date. The provider told us they had procured patient safety software (datix) to enable consistent reporting of significant events and planned to 'go live' later in the year when the IT platform at all their OOH locations had been configured to support this.
- Staff at the Lewisham location told us they had not reported any significant events but would fax a copy of the incident form or telephone the duty doctor at the Dulwich administration base for any incidents requiring immediate action.
- The provider told us that no significant events had been reported for the Lewisham location in the 12 months prior to the inspection. We reviewed two incidents reported in 2015 and 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.
- In the absence of reported significant events for the Lewisham location in the past 12 months we looked at incidents reported at the Dulwich administration base for the same period to enable us to review the process. We saw the provider had carried out a thorough analysis of the significant events and ensured that learning from them was disseminated to staff.
- The provider shared outcomes and learning from significant events across all locations via a monthly newsletter which was emailed to all doctors working for the service. We reviewed the February 2017 newsletter and saw details of a significant event relating to a missed diagnosis and learning around verification of a death. Staff at the Lewisham location confirmed they received feedback from significant events via this process.
- We reviewed minutes of multi-organisation significant event meetings which was a forum to peer review and share learning from serious incidents in a 'Being Open' framework. These were attended by the SELDOC medical director and patient liaison and quality co-ordinator.

The provider had an alert policy and system in place for actioning safety alerts including medicine and equipment but it was unclear how it ensured the GPs working at the Lewisham location received these consistently. The GP we spoke with at the Lewisham location told us they had received an alert that day but had not received anything in the previous months.

Overview of safety systems and processes

The provider had systems, processes and services in place to keep patients safe and safeguarded from abuse. However, these required some refinement at the Lewisham location.

- The provider had safeguarding children and vulnerable adults policies and social service referral forms available for staff working at the Lewisham location. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The provider's medical director was the safeguarding lead for the organisation. The GP we spoke with at the Lewisham location was aware of their responsibilities regarding information sharing and how to contact relevant agencies out-of-hours. However, they were not aware of the process of the referral form and told us they would liaise with the duty doctor at the Dulwich administration base. The provider told us there had been no safeguarding referrals from the Lewisham location in the 12 months prior to our inspection. Over the course of a 12-month period it is unlikely that a service of this size and type would not have needed to make a safeguarding referral. We saw evidence that the GP we spoke with at the Lewisham location was trained

to child safeguarding level three and had undertaken safeguarding adults training. However, the provider could not provide evidence that two of the 15 GPs working at the Lewisham location had been trained in child safeguarding or five of the 15 had been trained in adult safeguarding.

- The provider had a chaperone policy which outlined the roles and responsibilities for SELDOC staff acting as a chaperone. However, at the Lewisham location the doctors worked alone and chaperoning was undertaken by the hospital trust reception staff. There was no formal arrangement in place and the provider could not confirm that the reception staff who acted as a chaperone 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). We saw a notice in the waiting room at the location that advised patients that chaperones were available, if required.
- We observed the premises to be clean and tidy and the service maintained appropriate standards of cleanliness and hygiene. The provider had identified an infection control lead who had oversight of the Lewisham location but the primary responsibility for infection control on site was the hospital trust whose consulting room and shared waiting area was being utilised by the service. There was a system in place to report cleaning and facilities issues back to the hospital trust. There was a SELDOC infection control policy available for staff at the location which included standard precautions, managing sharps injuries, blood and bodily fluid spillage and waste management. The hospital trust had undertaken an infection control audit in January 2017 which included the consulting room utilised by the service. The provider told us this had identified torn fabric on the consulting room chair but this had not been replaced at the time of our inspection. The provider told us they had followed this up with the hospital trust. The provider did not maintain a record that GPs working at the Lewisham location had up-to-date infection control training.
- We reviewed a sample of five personnel files from the team of GPs who had regularly worked at the Lewisham location in the last 12 months, of which three were substantive staff and two were agency locum staff. We found appropriate recruitment checks had been undertaken prior to employment, 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 service at the Lewisham location did not hold stocks of medicines or controlled drugs (medicines that require extra checks and special storage because of their potential misuse). The provider told us the Lewisham location did not hold stocks of medicines as the service was provided by a sole GP on each shift, there was no SELDOC on-site reception or administration support and storage and security of medicines in a shared consulting room and shared facility could not be assured. The provider told us there were five pharmacies located within walking distance of the service of which one was open until midnight.
- There were no vehicles used as part of the out-of-hours service at the Lewisham location and there were no doctors' drug bags.
- Clinical equipment used by the clinical team at the location was provided by SELDOC and we saw evidence that this had been calibrated according to the manufacturer's guidance.
- The provider told us a new process and supporting policy to manage blank prescription form security at the Lewisham location had been implemented. Blank prescriptions were replenished from the Dulwich administration base and kept in a keypad combination locked cupboard at the Lewisham location when the service was not operating. We saw evidence that serial numbers were logged of prescriptions transferred from Dulwich to Lewisham. It was the responsibility of the duty doctor at the Lewisham location to lock away the unused prescriptions at the end of each session, log any prescriptions damaged or destroyed and advise the duty doctor at Dulwich if more prescriptions were required. We saw at the Lewisham location that there was a form for the new process. However, the GP we spoke with was unsure about the new logging procedure. The provider told us the new process had just been introduced and the policy has not been distributed to all GPs at the time of our inspection.
- The provider had employed a pharmacy adviser in May 2016 whose duties included ensuring medicine

management-related policies and procedures were up-to-date and relevant to the service, ensure prescribing was in accordance with best practice guidelines for safe prescribing through audits.
- We saw evidence that medicine management-related policies and procedures were available at the Lewisham location which included controlled drug prescribing policy, high risk medicines prescribing policy and formulary policy. Primary care antimicrobial treatment guidelines were also available.

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.

- The provider had identified a health and safety lead who had oversight of the location, maintained records and liaised with the hospital trust on all aspects of health and safety.
- The hospital trust had undertaken a variety of risk assessments to monitor safety of the premises such as environmental, infection control and Legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- A fire risk assessment had been undertaken in December 2015 and we saw evidence of annual maintenance of the fire warning system and fire extinguishers.
- All electrical equipment was checked by the trust to ensure it was safe to use. Clinical equipment used by the SELDOC team was maintained separately by the provider and we saw that this had been calibrated according to the manufacturer's guidance.
- 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.
- 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. The provider told us that that 80% of GPs working at the Lewisham location were local GPs from the cooperative's practices and 20% were locum GPs. We reviewed data of locum usage and found for the period 1 January 2016 to 31 December 2016 the service used 88% SELDOC GPs and 12% locum GPs.

Arrangements to deal with emergencies and major incidents

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

- The service was located within the Urgent Care Centre of the hospital trust and operated within its emergency response protocol through the standard crash call telephone number. A defibrillator, oxygen with adult and children's masks and emergency medicines were available centrally within the Urgent Care Centre. We saw that the consulting room also had an alarm bell to alert staff to any emergency. The GP we spoke with was aware of the emergency response system and the location of emergency medicines and emergency equipment.
- Thirteen out of the 15 GPs working had the Lewisham location had provided evidence to the provider that they had received annual basic life support training.
- The provider 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 directors, operations managers and staff.

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 provider had systems in place to keep all clinical staff up to date but told us there were no formal systems in place to ensure staff at the Lewisham location had access to these consistently.
- We saw evidence that the provider had organised clinical educational evenings for its GPs.

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.

We reviewed NQR standards for the period January to December 2016 and found performance for the service provided at the Lewisham location showed the following:

NQR 12 requires that providers have systems in place to ensure the following:

- 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 100%), after the definitive clinical assessment has been completed. In each of the last 12 months (January to December 2016) the service had achieved 100%.
- 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 12 months (January to December 2016) the service had achieved between 95% and 100%.
- Face-to-face consultations (whether in a centre or in the patient's place of residence) of less urgent patients must be started within four hours (with a target time of 95%), after the definitive clinical assessment has been completed. In the last 12 months (January to December 2016) the service had achieved between 97% and 100%.

Telephone clinical assessment (NQR9) of all patients seen at the Lewisham location were managed at the administration base in Dulwich. We did not inspect this location as it has been previously inspected as a separately registered location. However, we did look at performance data for the period January to December 2016 for NQR9 which requires that the provider have systems in place to ensure the following:

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person with a target of over 95%. In the past 12 months (January to December 2016) the service had achieved its target 11 months out of 12 months. We noted that in January 2016 the service had achieved 94%.
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person, with a target of over 95%. In the past 12 months (January to December 2016) the service had achieved its target eight months out of 12 months. We noted that in the months of January, February, November and December the service had achieved between 90% and 94%.

The service undertook a monthly review of one per cent of patient contacts in line with National Quality Requirement (NQR) 4.

We saw evidence of daily performance monitoring undertaken by the service. This ensured a comprehensive understanding of the performance of the service was maintained.

The service had a plan of audits which involved at least one audit per month and included formulary adherence, high risk medicines, antibiotic prescribing and repeat prescription requests. The provider shared with us two audits it had recently undertaken at the Lewisham location which related to broad spectrum antibiotic prescribing and high risk medicines.

The findings of the antibiotic prescribing audit for the period November 2016 to February 2017 which reviewed

Good

Are services effective?

(for example, treatment is effective)

the prescribing of five antibiotics (cefalexin, coamoxiclav, ceftriazone, ciprofloxacin and ofloxacin) to see if they had been appropriately prescribed, for the correct duration and adhered to CCG guidelines showed:

- Cephalexin: 74% had been appropriately prescribed, 56% for the correct duration and 74% adhered to CCG guidelines.
- Coamoxiclav: 58% had been appropriately prescribed, 56% for the correct duration and 49% adhered to CCG guidelines.
- Ciprofloxacin: 67% had been appropriately prescribed, 45% for the correct duration and 55% adhered to CCG guidelines.

No patients had been prescribed ceftriazone and ofloxacin in the audit period. The provider told us they would feedback the audit results to the GPs and repeat the audit as necessary.

All GPs were audited on a monthly basis utilising the RCGP Urgent and Emergency Care Clinical Audit Toolkit 2010. Feedback was provided on a quarterly basis unless the pass rate of 80% was not met and then meetings were expedited. We reviewed the performance reports of five GPs working at the Lewisham location and saw that they had all achieved the 80% pass rate.

Effective staffing

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

- The service had a formal induction programme for all newly appointed staff which was accessed through an induction and training portal on the provider's website. Each staff member registered individually to complete all modules. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety, moving and handling and equality and diversity. All GPs had a duty doctor handbook which included details of the SELDOC locations and useful contact telephone numbers, for example safeguarding information.
- Although we saw evidence that the management and administration team supporting the Lewisham location had received training in safeguarding, fire safety awareness, infection prevention and control, basic life support and information governance, the provider could only demonstrate evidence of training for its GPs based at the Lewisham location in safeguarding children, safeguarding adults and basic life support training. We also noted that there were some gaps in those training records for these GPs.
- The learning needs of staff were identified through a system of performance reviews, meetings and review of service development needs.

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.

- The service shared relevant information with other services in a timely way. Where patients used the service, a report detailing the care that they received was sent to the patient's GP by 8am the day following the consultation.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred.
- The electronic record system enabled efficient communication with GP practices and other services.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients using the out of hours service.

Consent to care and treatment

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

- Staff we spoke with at the location 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.

- During the inspection we observed that patients were called individually from the waiting area by the doctor.
- We noted there was no curtain in the consulting room to maintain patients' privacy and dignity during examinations, investigations and treatments. However, the door did lock. The provider told us they had asked the hospital trust for a privacy screen but this had not been provided. The provider told us they would follow-up with the trust again after the inspection.
- We noted that the consultation room door was closed during consultations; conversations taking place in the room could not be overheard in the waiting area.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the service offered a good, prompt and efficient service and staff were helpful, caring and treated them with dignity and respect.

The National Quality Requirement (NQR) 5 states that the provider must regularly audit a random sample of patients' experiences of the service (one per cent per quarter) and report audit outcomes to the contracting Clinical Commissioning Group (CCG). We reviewed quarterly quality monitoring reports provided for the CCG and saw patient survey outcomes were analysed. However, the data was the amalgamated results of all the provider's south east London locations in the boroughs of Lewisham, Southwark and Lambeth so we were unable to ascertain the results for the Lewisham location.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received stated patients felt involved in decision making about the care and treatment they received, had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

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. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format which included a bereavement leaflet which had been produced by the provider.
- The practice had a hearing loop in place for patients with a hearing impairment.
- The provider's website had the functionality to translate to other languages and increase font size for the visually impaired.
- The provider had produced a patient leaflet which guided patients on how to access the service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

No patients were registered at the service as it was designed to meet the needs of patients who were consulting a general practitioner out-of-hours. The service was by appointment only and was managed at the Dulwich administration base.

The service was provided from a consulting room within the Urgent Care Centre at University Hospital Lewisham. During the day on week days the consulting room was used by the hospital trust. The service shared a waiting area with the Urgent Care Centre. The provider had noadministration staff located at the Lewisham site. Reception was provided by the hospital trust who checked patients in and instructed them to sit outside the out-of-hours consultation room. The GPs called patients by name from the waiting area.

At our inspection we observed:

- 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.
- There were accessible facilities, a hearing loop and translation services available.
- Toilets were available for patients attending the service, including accessible facilities with baby changing equipment.

Access to the service

The GP-led, appointment only out-of-hours service operated on Monday to Friday from 8pm to midnight and at weekends and bank holidays from 10 am to 10pm. Patients could access the service directly, diverted when calling their GP out-of-hours or via the NHS 111 service. The service did not see 'walk in' patients and those that came in were seen by the Urgent Care Service situated in the same location. 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 CQC comment cards and from the National Quality Requirements scores indicated that patients were seen in a timely way.

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 co-ordinated the handling of all in the service.
- There was a complaint leaflet available to help patients understand the complaints system. There were no posters in the waiting room advising patients how to complain due to the shared nature of the facility. The provider website had the facility to feedback to the provider.

The service reported that there had been two complaints in the past 12 months. We reviewed both cases and found they were satisfactorily handled and dealt with in a timely way. We noted that the responses offered an apology, were empathetic and provided clear explanations. The letter included details of the Parliamentary Health Service Ombudsman in line with guidance.

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. Learning outcomes were also shared at pan-London provider meetings.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

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

- The corporate vision and mission statement were posted on a staff notice board at the base site. Staff we spoke with understood the vision, values and mission.
- The service had a robust strategy and supporting business plans that reflected the vision and values and were regularly monitored.

Governance arrangements

Although the organisation had an overarching governance framework that supported the delivery of the strategy and good quality care there was a lack of governance oversight at the Lewisham location. In particular, ensuring staff were aware of organisational policy and changes, maintaining up-to-date staff training records and dissemination of safety alerts and NICE guidance. Furthermore, the provider did not have a formal agreement in place for the use of hospital trust staff providing a chaperone service for its patients and could not demonstrate that they 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).

However, we found structures and procedures in place ensured that:

- There was a clear organisation and operations team structure. Staff were aware of their own roles and responsibilities within the structure.
- Service specific policies were implemented and were available to all staff. However, these were only available in paper copy at the Lewisham site as the hospital IT platform did not support the provider's intranet.
- 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.

Leadership and culture

On the day of inspection the provider told us they prioritised safe, high quality and compassionate care. Staff told us the management team were accessible although they did not work in the same premises as those at which the service was based. Lone workers at the Lewisham location were supported via telephone by a duty doctor based at the Dulwich administration base.

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 support 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.

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 staff workshops, newsletters and emails 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. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Requires improvement

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

- The provider held a board meeting, in public once a year. We saw evidence of minutes of the meeting which were also available on the provider's website.
- Patients were provided with an opportunity to provide feedback and, if necessary, complain. The provider undertook a random sample of patients' experiences of the service (one per cent per quarter) for its south east London locations in the boroughs of Lewisham, Southwark and Lambeth. The provider could not provide data solely for the Lewisham location.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- Staff we spoke with were proud of the organisation and its status as a community-based co-operative. Staff told us the organisation was involved in patient and public engagement and had participated in health fairs in the local community, a carers' event and sponsored a local youth football club.
- Staff told us that the organisation had celebrated its twentieth anniversary in 2016 and had held a celebratory event which included an awards ceremony. The event included representatives from stakeholder organisations across Lambeth, Southwark and Lewisham.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

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:** The provider was failing to ensure safeguarding children and adults training was up-to-date, staff providing a chaperone service were trained and had received a Disclosure and Barring Service (DBS) check, and staff were kept up-to-date with safety alerts and national guidance. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not have adequate governance oversight of the location and was failing to ensure there were effective systems and processes in place to keep staff at the location aware of local systems, protocols and policy changes. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.