Grabadoc Healthcare Society Limited

Quality Report

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

Ratings

Overall rating for this service	Not sufficient evidence to rate
Are services safe?	**Not sufficient evidence to rate**
Are services effective?	**Not sufficient evidence to rate**
Are services caring?	**Not sufficient evidence to rate**
Are services responsive to people's needs?	**Not sufficient evidence to rate**
Are services well-led?	**Not sufficient evidence to rate**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at GRABADOC Healthcare Society Limited on 30 March 2017. There was not sufficient evidence for us to rate the service; however our key findings across all the areas we inspected were as follows:

- The governance arrangements in place were not effective in assessing, monitoring and improving the quality and safety of the services provided, and did not assess, monitor and mitigate risks to service users.
- The provider did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely.
- Non clinical staff had been trained to provide them with the skills, knowledge and experience to perform their role effectively with the exception of providing formal chaperone training for staff expected to carry out the chaperone role.
- The provider did not ensure the proper and safe management of medicines by evaluating and monitoring the prescribing of medicines.
- The provider had not reviewed or assessed patient care needs and ensured care was delivered 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 did not seek and act on feedback from patients to continually evaluate and improve services.
- Information about how to complain was available and easy to understand.
- The provider did not seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity for the purposes of continually evaluating and improving services.
- The service had good facilities and was well equipped to treat patients and meet their needs, with the exception of facilities for hearing impaired patients.

The areas where the provider must make improvement are:

- Assess services provided to ensure that the care and treatment of service users is appropriate and meets their needs.

Summary of findings

- Ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely, and maintain an effective record of this.
- Ensure the proper and safe management of medicines by monitoring and evaluating prescribing.
- Establish and effectively operate systems and processes to assess, monitor and improve the quality and safety of services provided and to assess, monitor and mitigate risks to service users.

The areas where the provider should make improvement are:

- Consider ways to review clinical effectiveness and improve patient outcomes.
- Review how patient feedback is collected, considering a patient survey.
- Review facilities provided for patients with hearing difficulties to ensure their needs are met.
- Review systems and process in place with other services to ensure that; clinical guidelines are followed, patients are effectively safeguarded from abuse, and that clinicians providing clinical services are appropriately trained, qualified and competent for the role.

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?

There was not sufficient evidence available to rate the service for providing safe services; however:

- The provider did not provide formal chaperone training for staff expected to carry out the role.
- There were systems and processes in place to safeguard patients from abuse.
- Medicines were managed effectively.
- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- The provider had systems in place for reporting and recording significant events.
- When things went wrong with care and treatment the provider had systems in place to inform patients in keeping with the Duty of Candour.

Not sufficient evidence to rate

Are services effective?

There was not sufficient evidence available to rate the service for providing effective services; however:

- The service was not participating in the National Quality Requirements (performance standards) for GP out of hours services as the provider no longer held an out of hours contract.
- The service had systems in place to keep clinical staff up to date with relevant guidelines from NICE; however, GPs providing clinical services were expected to be updated by their own practice and the provider did not monitor that relevant guidelines were followed.
- The provider did not have a quality improvement programme in place.
- The provider did not ensure clinical staff had the skills, knowledge and experience to deliver effective care and treatment as this was seen as the role for the GPs' own practices.
- There was evidence of appraisals and personal development plans for all non-clinical staff, but not self-employed GPs providing clinical services.

Not sufficient evidence to rate

Are services caring?

There was not enough information to rate the service for providing caring services; however:

Not sufficient evidence to rate

Summary of findings

- We accessed various sources for feedback from patients about the service they received.
- The provider had systems in place for collecting feedback including verbal and written comments and complaints. The provider had received no complaints in the last 12 months.
- The national GP patient survey asks patients about their satisfaction with GP led services, including out of hours providers. There was no survey data available for this service.
- As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. No comment cards were completed.
- We were unable to speak with any patients during our inspection as there were no patient requests for clinical advice or treatment and no patients attended the service.
- The service did not participate in the NHS friends and families test and did not carry out patient surveys.

Are services responsive to people's needs?

Not sufficient evidence to rate

There was not sufficient evidence available to rate the service for providing responsive services; however:

- The provider had not reviewed the needs of its local population or 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, with the exception of the provision of facilities for hearing impaired patients.
- We saw evidence that GPs providing clinical services ensured that 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 however the provider had not received any complaints in the last 12 months.

Are services well-led?

Not sufficient evidence to rate

There was not sufficient evidence available to rate the service for providing well-led services; however:

- Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of services provided.
- Systems and processes were not established or operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

Summary of findings

- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, with the exception of providing formal chaperone training.
- The provider did not maintain records of clinical staff providing clinical services to ensure they were qualified, experienced and competent for the role.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Non-clinical staff had appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform.
- Service policies were available to all staff.
- Systems and processes were in place to safeguard patients from abuse.
- The service had systems in place to gather feedback from patients and staff.

Summary of findings

What people who use the service say

We reviewed various sources for feedback received from patients about the service they received.

The provider had systems in place for collecting feedback including verbal and written comments and complaints. The provider had received no complaints in the last 12 months.

The national GP patient survey asks patients about their satisfaction with GP led services. There was no survey data available for this service.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. No comment cards were completed.

We were unable to speak with any patients during our inspection there were no patient requests for clinical advice or treatment and no patients attended the service.

The service did not participate in the NHS friends and families test and did not carry out their own patient surveys.

Grabadoc Healthcare Society Limited

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 and a service manager specialist adviser.

Background to Grabadoc Healthcare Society Limited

Greenwich and Bexley association of doctors on call (GRABADOC) Healthcare Society Limited are registered with the CQC as an out of hours service providing the regulated activities of:

- Transport services, triage and medical advice provided remotely;
- Maternity and midwifery services;
- Treatment of disease, disorder or injury;
- Diagnostic and screening procedures.

The provider does not currently provide out of hours services, but does offer telephone answering services and the hosting and administration of GP services on behalf of GP practices in the Greenwich and Bexley area.

The GRABADOC service is located at 394 Shooters Hill Road, Woolwich, London, SE18 4LP and operates from converted residential premises over two floors. Ground floor accommodation includes reception and waiting area with patient facilities including accessible facilities and baby change area, consulting rooms, clinical telephone assessment area, staff offices and staff facilities. The first floor has staff facilities, administrative space and a meeting room. There is secure parking for multiple vehicles at the rear of the property.

Telephone answering services are provided on an ad hoc basis as and when practices require them, for example when practices may be closed for training, with one practice also using the service on a regular daily basis from 5.00pm until 6.30pm when the practice is closed. Calls from patients are answered at the GRABADOC service by non-clinical GRABADOC staff. Patients are given advice to call back their practice when it is open for routine calls such as appointment booking, and patients requiring clinical assessment will have their details passed back to their practice on duty GP.

The service also hosts and administers GP clinical services on behalf of three local GP practices weekly on a Thursday afternoon. Patients calling their practice during the hours of 1.30pm until 6.30 pm will be diverted to or directed to call the GRABADOC service. Calls are answered by a GRABADOC call handler. Patients requiring routine, non-urgent action such as appointment booking are asked to call their practice back during normal opening hours. Patients requiring or requesting clinical assessment have their details passed to the GRABADOC GP on duty where a clinical assessment is made and treatment provided over the telephone. In cases where the GP needs to see the patient, they are asked to attend the GRABADOC service in person, or the GP can arrange to visit the patient at home.

GRABADOC services are provided on behalf of GP practices in the Bexley CCG and Greenwich CCG areas. The combined total number of patients who have access to the service is

approximately 19,500 patients. In the last 12 months, the service has been accessed 57 times, including two home visits, four face to face consultations, two walk in patients and 49 telephone consultations.

The service is operated by two medical directors and a chief operating officer, supported by an operations manager, finance officer and administrative receptionist. The clinical service is provided through a bank of self-employed GPs from the local practices contracted to the service.

The service has previously been inspected by CQC in 2014 and met the required standards for the GP out of hours service being provided at that time.

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 30 March 2017.

During our visit we:

- Spoke with a range of staff including the chief operating officer, finance officer, operations manager and a GP providing the clinical service.
- Did not speak with patients as no patients accessed the service during our inspection.
- Inspected the premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.

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.

Not sufficient evidence to rate

Are services safe?

Our findings

Safe track record and learning

The provider had systems 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's 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 that the provider had systems in place that if something went wrong with care and treatment, patients would be informed of the incident, receive support, an explanation based on facts, an apology where appropriate and be told about any actions to improve processes to prevent the same thing happening again.
- The service told us they would carry out a thorough analysis of the significant events and ensure that learning from them would be disseminated to staff and embedded in policy and processes.
- The provider told us they had not had any incidents and had no recorded incidents for the inspection team to review.
- We spoke to the duty GP during our inspection who told us they would report any significant event to the GRABADOC clinical lead.

Overview of safety systems and processes

The service had systems, processes and services in place to keep patients safe and safeguarded from abuse, however these were not always effective:

- The service had arrangements in place to safeguard children and vulnerable adults from abuse; however, these arrangements were put in place by the provider when the out of hours service operated. We found that arrangements had been recently reviewed but did not reference wider CCG level arrangements for safeguarding.
- Policies were accessible to all staff and the policies outlined who to contact for further guidance if staff had concerns about a patient's welfare, including the GRABADOC lead member of staff for safeguarding.
- GPs working in the service told us they would use safeguarding policies and procedures they were familiar with from their own practice, and inform the GRABADOC clinical lead of any referrals.
- The GP we spoke with during our inspection demonstrated they understood their responsibilities and we saw evidence they had received relevant training on safeguarding children and vulnerable adults and were trained to child safeguarding level 3. The provider did not keep records demonstrating clinicians were appropriately trained in safeguarding. We did see records demonstrating non-clinical staff had received online level 1 safeguarding training.
- A notice in the waiting room advised patients that chaperones were available if required. There was one member of staff who told us they would act as a chaperone if required and we saw evidence they had checks carried out through the Disclosure and Barring Service (DBS); however, they had not had formal chaperone training and told us they would work under the instruction of the GP. (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 premises to be clean and tidy. There was an infection control lead. There was an infection control protocol in place and non-clinical staff had received up to date training relevant to their role. GPs providing the service told us they had received infection control training. The service carried out and recorded monthly infection control checks. Annual infection control audits were also undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, the service had replaced bins with new foot pedal operated bins in patient waiting areas and toilets, removed plugs from sinks and provided examination gloves in a variety of sizes. Results of audits, significant events relating to infection control, risk assessments and a review of training, policies and procedures were presented to the provider leadership in an infection control annual statement.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with

manufacturers' guidance, with regular servicing and calibration of clinical equipment such as scales, thermometers and blood pressure monitoring equipment.
- We reviewed two personnel files for non-clinical staff employed and 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.
- The provider did not hold personnel records for the self-employed GPs providing the service; however, we were able to see records provided by the GP working during our inspection. These records showed that the GP was on the NHS performers list, the General Medical Council (GMC) register, had medical indemnity insurance, and had training in basic life support (BLS), Child and adult safeguarding and the Mental Capacity Act (MCA).

Medicines Management

The provider had arrangements in place for managing medicines and emergency medicines which were designed to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The service did not hold stocks of controlled drugs (medicines that require special storage and security arrangements to prevent misuse). The provider and clinical staff we spoke to told us that:

- The provider did not carry out regular medicines audits to ensure prescribing was in accordance with best practice guidelines for safe prescribing.
- Clinicians providing the service would prescribe in line with their own practice prescribing guidelines, and the practices would monitor prescribing.
- GPs would normally carry their own supply of blank prescription forms in their doctors bag collected from their own practice, however the service also stocked blank prescription forms and pads which were securely stored and there were systems in place to monitor their use.
- We saw evidence that processes were in place for checking emergency medicines.

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 with a poster in areas accessible to all staff that identified local health and safety representatives. The service had up to date fire risk assessments and carried out regular fire drills. 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 service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection prevention and control and Legionella (Legionella are bacteria which can contaminate water systems in buildings).
- The provider did not supply vehicles for clinical staff to use to visit patients at home where required; the GPs used their own vehicles.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The provider ensured there were non-clinical staff available at all times the service was in operation. Clinical staff were arranged on a rota basis coordinated by the GPs on the rota. The inspection team saw evidence from previous rotas and interviews with staff, that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand.

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.
- Non clinical staff records showed they had received annual basic life support (BLS) training, including use of an automated external defibrillator. Records were not available to demonstrate all clinical staff had received BLS training. The GP we spoke to during our inspection demonstrated they had received BLS training and that this training was in date.
- The service had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

Not sufficient evidence to rate

Are services safe?

- 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 staff.

Not sufficient evidence to rate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service had not assessed needs and ensured care was delivered 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 clinical staff up to date with relevant guidelines from NICE; however, GPs providing clinical services were expected to be updated by their own practice.
- The provider did not monitor that these guidelines were followed.

Management, monitoring and improving outcomes for people

The provider did not have a quality improvement programme and the service did not participate in local audits, national benchmarking, accreditation, peer review or research.

Information about patients' outcomes was not available, collected, monitored or used to make improvements.

Effective staffing

Non clinical staff had the skills, knowledge and experience to effectively carry out their role. The provider did not keep records demonstrating clinical staff had the skills, knowledge and experience to effectively carry out their role.

- The GPs working in the service did not have direct clinical supervision, monitoring, support, appraisals or training needs analysis. Clinical support and advice was available from the GRABADOC clinical lead where required; however, all other support and monitoring was undertaken through the GP's normal practice.
- The service had an induction programme for newly appointed non clinical staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality relevant to the role. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period.
- The learning needs of non-clinical 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 where identified. All non-clinical staff had received an appraisal within the last 12 months.
- Non clinical staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Non-clinical staff had access to and made use of e-learning training modules and in-house training.
- The provider had an induction programme for newly appointed clinical staff relevant to their previous out of hours contract; however, this was not in use at the time of the inspection.

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 computer system.

- This included access to required summary care record which detailed information provided by the person's GP. This helped understanding a person's needs.
- Patients who could be more appropriately seen by their registered GP or an emergency department were referred.
- GPs in the service sent notes to the patients' registered GP service electronically on the same day they used the service.

Consent to care and treatment

Clinical staff we spoke with told us they 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 told us they 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 told us they would assess the patient's capacity and record the outcome of the assessment.
- We were not able to corroborate what we were told as the service did not have access to individual patient records.

Not sufficient evidence to rate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We were not able to observe whether members of staff were courteous and helpful to patients and treated them with dignity and respect as no patients used the service during our inspection.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We were told that consultation and treatment room doors were closed during consultations; we observed that 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.

No care quality commission comment cards were completed prior to our inspection and the provider did not carry out their own patient satisfaction survey.

The national GP patient survey asks patients about their satisfaction with services. There were no results available for the service.

Care planning and involvement in decisions about care and treatment

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 and languages other than English.
- There were no facilities for people with hearing impairment such as a hearing aid loop. Staff told us they would communicate in writing with hearing impaired patients if required.

Not sufficient evidence to rate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider had not recently reviewed the needs of its local population or engaged with its commissioners to secure improvements to services where these were identified. However, we found that:

- Home visits and telephone consultations were available for patients whose clinical needs resulted in difficulty attending the service.
- There were accessible facilities and translation services available.
- Facilities for hearing impaired patients were not available.

Access to the service

The service was open between 9.00am and 5.00pm Monday to Friday for administrative functions and services. Clinical services operated from the site between 1.30pm and 6.30pm every Thursday. The service did not operate at weekends or bank holidays.

We saw records showing numbers of patients attending the service during the previous 12 months and noted there were 57 patient contacts in total, comprised of four consultations at the location inspected, two home visits, 49 patients provided with advice or treatment over the phone and two walk in patients.

The service did not allow for walk in patients and would advise them to ring their own GP or NHS 111 unless they needed urgent care, in which case they would be stabilised before referring on.

The provider did not have a system in place for GPs to assess whether a home visit was clinically necessary and the urgency of the need for medical attention; however, GPs were expected to follow their own practice policies and procedures. The GP we spoke with during our inspection told us they would telephone the patient requesting a home visit and either advise the patient to contact their own GP for non-urgent matters, or arrange a home visit to be conducted as soon as possible for urgent matters. We saw records showing there had been two home visits conducted in the previous 12 months, both of which were prioritised as urgent.

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 the NHS England guidance and their contractual obligations.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service.
- We saw that information was available to help patients understand the complaints system in the form of a complaints leaflet and information on the service website.

The service had not received any complaints in the last 12 months; however, we were informed that complaints about the clinicians would be acknowledged by the provider, GRABADOC, and passed to the GP responsible for the patient's care at the time of the complaint and the practice the GP worked for. Complaints against non-clinical staff directly employed by GRABADOC would be handled by the provider in line with their policy.

Are services well-led?

Not sufficient evidence to rate

(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 vision to deliver high quality care and promote good outcomes for patients; however, this vision, the strategy and supporting business plans were reflective of previous services offered and not in line with the current operating model.

The provider had a mission statement and staff knew and understood the values.

Governance arrangements

The service had a governance framework which did not always support the provision of clinical services. The governance system in place was not reflective of the services being provided. We found that:

- The provider did not have clinical oversight of the care being provided.
- The provider did not ensure clinical staff were qualified, experienced and competent to fulfil their role.
- The provider did not ensure quality of care was monitored and continually improved.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, with the exception of providing formal chaperone training.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Non-clinical staff had appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform.
- Service policies were available to all staff.
- Systems and processes were in place to safeguard patients from abuse.

Leadership and culture

On the day of inspection the provider told us they prioritised safe, high quality and compassionate care. Staff told us the leadership team and management were approachable and always took the time to listen to staff.

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).

The leadership team encouraged a culture of openness and honesty. The provider had systems in place that complied with the NHS England guidance on handling complaints.

However, the provider told us that the responsibility for problems with care and treatment resided with the GP providing the service at the time of the incident and the practice the GP worked with.

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

- There were arrangements in place to ensure non-clinical staff were kept informed including face to face and electronic updates as well as team meetings.
- 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, particularly by the providers. Staff had the opportunity to contribute to the development of the service.

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

The service had systems to gather feedback from patients and staff, however these were not effective.

- The service had offered patients the opportunity to provide feedback through comment slips and complaints. The provider had not recorded any positive or negative feedback in the previous 12 months. Staff told us that verbal comments had been received about difficulty in finding the service. Staff responded by trying to make directions clearer over the phone and on the service website.
- The service had gathered feedback from non –clinical staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.

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
Diagnostic and screening procedures Maternity and midwifery services Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** • The provider did not ensure that the care and treatment of service users was appropriate or met their needs. This was in breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services 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 did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. • The provider did not ensure the proper and safe management of medicines This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services 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:**

This section is primarily information for the provider

Requirement notices

- The provider did not maintain securely such records as are necessary to be kept in relation to the persons carrying on the registered activity and the management of the regulated activity.
- Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of services provided.
- Systems and processes were not established or operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.