The Doctors Laboratory Limited

The Doctors Laboratory

Inspection report

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Date of inspection visit: 25 March 2022
Date of publication: 25/05/2022

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not rate this service. We found:

- The service had enough staff to provide the right level of service. Staff had training in key skills and managed safety well. The service controlled cross contamination risk well. Staff assessed risks and kept good care records. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, and had access to good information. Key services were available seven days a week.
- The service was planned to meet the needs of local people and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with other healthcare providers to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical laboratories	Inspected but not rated	We did not rate this service. See the summary above for what we found.

Summary of findings

Contents

Summary of this inspection

Background to The Doctors Laboratory

The Doctors Laboratory is a provider of clinical laboratory diagnostic services, this means they process tests taken at hospitals and other health care settings and provide the results. They test blood samples, tissue samples or other bodily product samples. The service also provides specialist support for other laboratories and for pharmaceutical and biotechnology research. The service also issues blood and blood products to the NHS and private sector.

The Doctors Laboratory has been registered with CQC since 2018 and has a registered manager in place to oversee the service. This service had not previously been inspected by CQC. The service had a central hub that was the registered location and a further 13 satellite locations across England.

The service has contracts with many NHS and private health care providers to provide their medical laboratory needs. They do not accept private requests from members of the public.

Laboratory tests funded by the NHS must be accredited against a set of standards called ISO 1518. The United Kingdom Accreditation Service (UKAS) is recognised by the government as the sole national accreditation body and once tests are accredited, there are annual surveillance activities and full re-assessment every 4th year.

In addition, all laboratories must participate in an external quality assurance (EQA) scheme that advises providers of their quality assurance results and how their results compare with other laboratories. This aspect of the service was not inspected.

How we carried out this inspection

This was an unannounced inspection using our comprehensive methodology. We did not rate this service. This is because CQC does not apply a rating to independent laboratory services.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service used computer programmes in novel ways which gave them the ability to have sight of data across all their laboratories and to feed information back to services that contracted them.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of this inspection

Action the service SHOULD take action to improve:

- The service should ensure they continue to improve their system to monitor staff appraisals to ensure data about appraisal recording is accurate.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical laboratories	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Medical laboratories

Safe	Inspected but not rated
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Medical laboratories safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff accessed training using a bespoke online education platform. This meant staff at geographically distanced laboratories received exactly the same mandatory training as staff who worked at the central hub.

The mandatory training system enabled managers to assign staff to particular groups to ensure they completed training appropriate for their specific role.

Staff were mostly compliant with their mandatory training completion. At the time of inspection, the service was meeting its target for training completion.

Safeguarding

The service was able to support care providers to identify patients who were potentially at risk.

The service was able to break down their data to drill down to certain care providers and certain tests and/or results. This meant if a commissioner were concerned about a particular care provider they could ask the laboratory to pull a report of their recent tests results, to see if there were systemic concerns about care.

Staff did not have any direct patient contact and therefore it was not necessary for them to have safeguarding training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect themselves and others from infection and prevent cross contamination of specimens. They kept equipment and the premises visibly clean.

Staff were provided personal protective equipment (PPE) to keep themselves safe from any potential infection risk. This had the dual benefit of reducing the risk of staff contaminating samples.

Laboratories were carefully designed to allow a flow of samples to reduce risk of cross contamination.

Laboratories where required were air pressured, with control mechanisms to maintain the air pressure in the room. This ensured air flow was predictable and reduced the risk of cross contamination.

Laboratories were spacious and enabled social distancing to be observed.

The service had policies including handwashing, how to manage sharps injuries and splashes or spillages, waste management and PPE to support staff to work safely.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

When possible the service used mostly the same models of machines and analysers across their laboratories. This meant if staff moved between laboratories they knew how to use equipment.

Staff completed quality checks on all machines at regular intervals determined by the type of machine and suggested by the manufacturer.

The service had servicing contracts for their machines and they also regularly tested their accuracy, as required by UKAS for accreditation. The details of the service contract and the types of machines were kept in an equipment log.

The service kept back up parts for their analysis machines. Individual laboratories kept logs of any machine breakdowns, these logs were used to support decisions about when to replace machines.

When required, samples and specimens were stored in temperature controlled conditions to allow retesting. There were defined time frames different samples were stored for. Once a sample had passed this time it was disposed of. Fridge and freezer temperatures were automatically monitored and the system automatically sent a text if the temperature was outside of set limits.

Assessing and responding to patient risk

Staff prioritised results where patients needed urgent medical attention and made sure results were available for the person who requested the test as soon as possible.

The service had a policy that outlined how and when urgent test results could be shared with referring health care professionals. This policy included checks, such as identification checks, which must be completed to ensure the right information is shared about the right patient. This was also to ensure a patient's right to privacy was maintained, and information was only shared with whoever requested it.

Laboratories that accepted urgent tests had large screens in them which linked up to the testing system. These screens showed how many tests were nearing their time for processing. This gave laboratory staff a clear visual reminder if there were tests that needed prioritising.

Laboratories reported urgent tests directly into the referring centres electronic pathology systems which enabled quicker access.

Inspected but not rated

Medical laboratories

Laboratory staffing

The service had enough laboratory staff with the right qualifications, skills, training and experience to provide the right level of service. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Laboratory staffing was managed locally, with laboratory managers being responsible for ensuring staffing numbers were safe. We were told one way the manager monitored staffing need was to look at over time. If staff were regularly needing to work overtime it was an indicator that more staff were needed. Often new positions were offered a temporary contract until the ongoing need was confirmed and then a permanent position was created.

Locally laboratories could access locum and bank staff to support with short term increases in work, or for unplanned absences.

Across almost all the laboratories there were reported safe staffing numbers, where areas were short staffed, due to a lack of expertly trained laboratory staff, these were raised on the risk register and laboratory capacity was monitored to ensure a safe service could be run. The service had a low vacancy rate and was actively recruiting into roles that were vacant.

The service monitored their staffing turnover rate. They told us in the past 12 months this had been higher than usual. We were told this was expected as, due to the pressures and uncertainty during the pandemic, they had offered more fixed term contracts to allow them flexibility in the workforce.

Laboratory staff shifts allowed a minimum of 30 minutes of overlap to allow time for staff huddles to handover information between shifts.

Senior clinical staffing

The service had enough medically qualified consultants and consultant-level scientists with the right qualifications, skills, training and experience to provide clinical advice.

The service had an overarching medical director who oversaw the local consultants and worked to ensure there was a collaborative and consistent approach between laboratories. The medical director ensured all consultants had an annual performance review, where they ensured consultants had a recent appraisal.

All laboratories were led by registered members of staff, who had the experience to take on this role.

There were overarching consultant leads for each pathology speciality to ensure consistency between the laboratories. We were told since meetings had moved onto digital platforms it had helped the consultants to be less “London centric” as consultants did not need to be able to attend meetings on site in London. This had enabled them to include more consultants in the conversations and work towards greater consistency across all laboratories.

At the time of inspection, we were told that there was good consultant cover at all laboratory sites.

Records

Staff kept detailed records of patients’ specimens. Records were clear, up-to-date, stored securely and easily available to all staff.

Inspected but not rated

Medical laboratories

All laboratories used electronic records to track and log requests and specimens. All specimens were given a unique barcode which enabled staff, or automated analysers, to accurately identify which sample was being tested and to attach the subsequent report to the correct record.

The patient records sat in a separate computer programme to the auditing system, to protect patient privacy. When data was pulled into the auditing and wider reporting system it was anonymised, and information was looked at on a laboratory or contractual level.

Medicines

The service stored and used medical reagents safely.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from safety alerts were implemented and monitored.

All the laboratories used the same incident reporting system. Incidents were investigated locally, within the laboratory and investigations were monitored by the central governance team, based at the main hub.

Learning from incidents was formally shared once a month at the laboratory quality management meetings, and as required between them.

Individual laboratory quality managers reviewed their incidents for any trends. They pulled a report every three months to look at the trends for the past three and six months, to see if trends were changing.

There were monthly governance and quality manager meetings which were an opportunity for the team to share any notable learning or trends with other managers to reduce the likelihood of incidents being repeated across the organisation.

The principal quality manager and the governance lead regularly looked at the incident reporting system to identify any themes or trends with incident reporting across the whole organisation. If trends were identified any learning was shared with the local quality managers to implement locally, as appropriate.

The principal quality manager and the governance lead also monitored the quantity of incidents reported by each laboratory, to ensure they were assured there was a good reporting culture in the laboratory. If they were concerned about the number of incidents being reported they would raise this concern with the local quality manager.

The service had a central manager who received all safety alerts and shared them, and any actions with the individual laboratories. The alerts were shared with the appropriate local laboratory staff groups, who needed to take actions.

Inspected but not rated

Medical laboratories

Are Medical laboratories effective?

Inspected but not rated

Evidence-based care and treatment

The service followed national guidance when presenting and interpreting results. Managers made sure staff followed quality control procedures.

The service contracted a number of speciality consultant leads to ensure any updates in gold standard guidance were implemented safely into local guidance. These changes were discussed at the "TDL consultant's meetings". The service told us they took a measured approach to switching to the new guidance and ensured they shared pertinent information with their own staff and the clinicians who referred into them.

When new versions of documents were introduced into the system the service built training time into the timeline for introducing policies. Most laboratories automatically emailed staff when documents were updated and electronically logged who had reviewed them. A small number of laboratories did not have this functionality. They used a paper based system supported by the quality managers and laboratory department administrators who were responsible for ensuring all staff had reviewed new documents.

Most laboratories used similar machines and equipment which meant there was general guidance for processes. In addition to this general guidance each laboratory had their own local policies and procedures, for their own workflows.

All documents in the system followed structured templates which included review dates and were version controlled. We were told if national good practice changed between the review dates this date was bought forwards.

There was a comprehensive audit programme for each individual laboratory, this was managed by the laboratory quality manager.

Patient outcomes

Staff monitored the effectiveness of their service. They used the findings to make improvements and achieved good outcomes. The service used quality assurance schemes to monitor and check their results. The service had ISO15189 accreditation.

The consultant leads for specialities were working to look at reports and to ensure they were consistent across different laboratories.

As described above there was a comprehensive audit schedule for each individual laboratory. The schedule reflected the standards set out by the United Kingdom Accreditation Service (UKAS) who were the body that gave laboratories their ISO15189 accreditation status. The audit schedule was designed to ensure between UKAS reviews the laboratories were still maintaining the high standards required to remain accredited. All audit results were reported into the service's central governance system, along with any identified areas for improvements and associated actions and were monitored by the governance lead.

Audit results and corrective or preventative actions were given time frames for completion, and re audit. Compliance with these time frames was monitored by the governance lead and the principal quality manager. When dates were overdue they spoke with local quality managers and service leads to understand what was causing a delay and if more support was required.

The service participated in external quality assessment schemes to ensure their results were accurate. External assurance schemes are national schemes where laboratories share results and ensure their results are within defined reference ranges and are therefore accurate. However, not every test had a national external quality assessment scheme. Where this was the case the service had set up a process between its own or other provider laboratories where they followed similar principles to ensure all their laboratories were giving accurate results.

Every laboratory the provider was responsible had achieved ISO15189 accreditation for all the tests they carried out.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

All permanent and bank staff were given an induction when they started their job. Any locum staff who were contracted to work for the service longer than four attended a full induction.

When staff started they were provided an induction pack, that was tailored to their role. The pack was completed and signed off locally and was then sent to the human resourcing team to scan in to hold accessible copies.

All staff were expected to complete competencies applicable for their roles, as competencies were completed they were signed off by local managers and sent to the human resourcing team to scan in and to hold accessible copies.

All staff were expected to have annual appraisals with their managers. At the time of inspection 37.4% of staff had completed their appraisals and 18.4% of staff were too new to have required an appraisal. This meant 44.2% of staff had not had an appraisal recorded who were expected to. The service had requested feedback on why these numbers were so low and had been told the system was difficult to complete. Changes had been made to the system to record appraisals, beginning in 2022, and it was hoped that the completion numbers would improve.

At appraisals staff were asked to reflect on what they did well and what they could improve upon and to identify any areas of extra learning.

Staff were able to request extra training or to attend courses throughout the year, and at their appraisal. All training requests went through a central meeting pending approval. This allowed the central human resources team to ensure staff had equal access to courses and training.

All laboratories had staff who were Health and Care Professions Council (HCPC) registered who were supported by clinicians, when required.

Multidisciplinary working

Staff worked with other providers' teams to benefit patients. They supported each other to provide a good service.

Inspected but not rated

Medical laboratories

The service worked closely with the health care providers that they held contracts with to ensure they were meeting their needs and the turnaround times were appropriate and safe. We were told of one laboratory that was being refurbished. In the process of planning the refurbishment the contracted service was involved to ensure the new analyser machines would be beneficial to the hospital.

Seven-day services

Key services were available seven days a week to support timely patient care.

All laboratories that accepted urgent samples worked 24 hours a day 7 days a week, to ensure results could be given in time for clinical decisions to be made.

Health promotion

Staff were not in a position to be able to give patients advice on how to lead healthier lives.

Staff did not have direct contact with patients, nor were they able to access their full care records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service had no direct communication with patients, therefore it was not their responsibility to obtain consent.

Are Medical laboratories responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

Managers planned and provided services to meet the needs of the health care providers who commissioned them. They continually worked with these health care providers to work out what services the local community needed.

Any new bids for contracts were reviewed by the service's medical director for approval, and to ensure the service had capacity in the right laboratories to provide these services consistently and safely.

The service had regular meetings with the health care providers they had contracts with already to ensure the contracts that were in place were still representative of the patient's needs. The frequency of the contract meetings was dependent upon the size of the contract.

One manager we spoke with described speaking with the managers at the local health care providers about providing instructional leaflets in different languages that the local population spoke, to ensure they were providing information in a way that made sense for patients.

Access and flow

People could access the service when they needed it and received the right tests promptly.

The service set their turnaround times and targets with the individual health care providers they had contracts with. We reviewed the turnaround time data for some of the larger contracts the service held and noted that they always met, and often exceeded the agreed turnaround time targets.

Inspected but not rated

Medical laboratories

We also reviewed data for individual laboratories, which managed smaller contracts as well as the larger contracts. The laboratories were also meeting all their turnaround time targets.

As described in "assessing and responding to risk" in "safe" staff were supported to achieve their turn around time targets by using technology to make it clear when tests were nearing their time to be completed on large screens in laboratories.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service had a policy for logging and responding to complaints. It included an explanation of duty of candour, when it might apply and how to ensure staff met the requirements.

The policy explained who was responsible for investigating a complaint and how to escalate complaints when they were received. It also set out time frames for any complaints to be acknowledged and responded to. In the year prior to inspection the service met their timeframes for responding to complaints 84% of the time. We were told the 16% that fell outside of their response time frames were complex complaints and that some actions had been identified before the full response was agreed.

Complaint investigations and responses were clear and thorough responded to the concerns raised in full.

The service discussed complaints received and responses to complaints at a monthly complaints, litigation, incidents and prevention meetings. In addition to these complaints were also discussed at the operational management group meetings and at the contract review committee meetings, so all necessary members of the team were aware of actions taken.

The service managers worked to identify any themes from complaints and took action to rectify these.

Are Medical laboratories well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were approachable in the service for staff. They supported staff to develop their skills and take on more senior roles.

Leaders were clear about the service and the way in which they were able to support it. We were told their ability to attend specific laboratories had been impacted by the ongoing COVID-19 pandemic, however they had opened up communications digitally to ensure they were available for staff.

They were clear about the challenges operating a service that was so geographically distanced could pose. Managers explained that service had gradually grown over the years, adding more laboratories slowly. This slow growth enabled them to develop clear lines of communication and support that meant even laboratories that were geographically distanced were supported by the team in London in a meaningful way.

Each individual laboratory had their own reporting structure including laboratory managers and quality managers. As a general rule each laboratory had a laboratory manager. If there were a number of laboratories on one site there would also be heads of department to support. The laboratory managers and heads of departments reported into operations managers. Operations managers reported into the director of group laboratory operations who reported to the group laboratory director.

These staff members were available on site for staff to approach. Laboratory staff told us their managers were approachable and they felt able to ask for support or to ask questions and raise concerns.

We were told succession planning was integral to the service functioning well. All senior job roles were supported by a more junior role who had insight into the responsibilities. This meant should a senior manager leave, or take an unexpected period of time off, there were people who were able to ensure their key tasks were completed to keep the service running safely.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

Staff we spoke with were all aware of the company values and referenced them throughout our discussions. Managers told us they referred to the values in staff appraisals. The service was focussed on reminding staff about their contribution to patient care, even though they never physically met the patients.

The service had a vision for the future to be the best diagnostic laboratory organisation and to embrace both contracts with the NHS and independent healthcare and to treat them the same, as the focus should be on patients. The service also wanted to retain its roots in being medically led and made efforts to ensure this remained the case.

There was a strategy to bring this to action. Over years the service had grown at a steady pace, but had been considered about how and when to grow to ensure it was done safely.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients. The service promoted equality and diversity in daily work, and provided opportunities for career development.

The service carried out staff surveys and acted upon the results of these. The surveys were short and were sent out every two weeks so they could track employee engagement almost in real time.

The staff survey included questions about equality, diversity and inclusion and whether all staff felt included and supported. Any identified actions from the survey were owned at a local level, by the head of department, level but were monitored by the central human resources team. Every month there was a heads of department meeting, it was expected that any actions from the staff survey were discussed at that meeting.

One manager we spoke with explained when they started staff raised concerns about opportunities to progress in their careers. Since this concern was raised the laboratory had made more effort to advertise clearly to members of the team when new roles were available, this had led to an increased number of internal applications and promotions.

Staff we spoke with felt the values of the service were right and helped them remember there were "patients at the end of the needle". They told us it was important to remember they were not just processing tests but that the timeliness of those results could impact on patient care.

Local laboratory staff told us they were able to access and apply for training. The human resources team reviewed applications for training, to ensure they were given out fairly and that certain members of staff were not given all the training, at the expense of others being held back.

Governance

Leaders operated clear and effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

All staff we spoke with were clear about the remit of their roles and what they were responsible for, who reported to them and who they reported to.

Senior leaders told us it was a balancing act to manage such a geographically dispersed service but as the service had grown slowly over years it meant clear lines of communication had been developed.

Along with managers and head of departments laboratories also had quality managers working in them. Quality managers were responsible for reviewing incident reports, audit schedules and the risk register amongst other things. All the quality managers reported into one principal quality manager who reported to the governance lead.

Supporting the managerial and quality managers were other teams including health and safety teams, human resources and the specialist medical staff (who reported to the medical director).

As described through this report the local laboratory teams met every month and information was shared at operational/performance monthly meetings and quality/governance monthly meetings. These meetings then fed into wider group meetings and to the executives meeting.

All meetings had terms of reference which informed the agendas and meeting minutes that we reviewed were clear and concise and had clear actions identified.

The service had regular meetings with the health care providers who they had contracts with, to discuss whether the contracts were still meeting the providers needs and if any changes were required. There was a process for agreeing new contracts, that included requiring clinical input to ensure the laboratory had the capacity and capability to undertake any extra work.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Each laboratory had their own risk register which was owned by the laboratory manager and the quality manager. The risk register described the risk, gave it a rating score, identified actions to reduce the risk, identified a person responsible for the actions and had an estimated date for these to be completed. Any risks that were rated above a certain number were still owned by the local laboratory but were also immediately reviewed and monitored by the central governance team.

The central governance team held a group risk committee meeting, which included the executive team, every two months. At the group risk committee, the team invited an external reviewer to attend to give unbiased challenge to any decisions on risks.

All risk registers and their associated actions and time lines were monitored by the central governance team, who reached out to laboratories if they looked to be struggling to achieve actions on time, or to reduce the risk ratings.

Where laboratories were based in particular hospitals and primarily served those services the local risk register was shared with that service to be open about any potential challenges it was facing.

The company as a whole also had a risk register, which was monitored by its senior leaders and executives.

The service had clear plans to manage unexpected events. We were told all roles were capable of being covered by other members of staff, should something happen to an individual, that there were external power generators available to ensure all laboratories could run safely in the event of a power cut and there were emergency plans in the event of other emergencies.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used consistent computer programmes across all laboratories to ensure information and data were gathered in a consistent way that meant it could be collated and reviewed.

Collecting so much detailed data meant the service was able to support local health care systems to identify any areas of concern in populations they processed tests for. This is described in more detail in “safeguarding”. When information was shared it was always done in a way that excluded any patient identifiable information.

Patient identifiable information was never exported into the services data management programmes, it remained in the reporting systems. The information that was imported into the central performance and quality management programmes was anonymised and used for trend analysis.

The service used the data and information it collected to make decisions about how to run, or expand services and where might need development and newer equipment.

All laboratories were accredited by UKAS under ISO15189.

Managers told us they submitted notifications, as required to other organisations and we saw reference to notifications being considered in meeting minutes. The service had previously been responsive to requests to information made by CQC.

Engagement

Leaders and staff actively and openly engaged the services who contracted them to plan and manage services.

The service had a team dedicated to contract management and understanding the needs of the services who contracted them. This team was responsible for explaining the service offering when "onboarding" health care providers with contracts, and for supporting them once they had contracted the service.

There was a call centre which health care providers could call to request information or support if this were required.

In addition to this, for larger contracts with clinical commissioning groups (CCG) the service met with them and were able to provide data on the outcomes of certain tests which gave the CCGs insight into the population health in their areas. A CCG is a commissioning group who decide where services are offered from.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had published a quality improvement newsletter to highlight areas identified for improvement and to encourage new quality improvement projects that had been started.

The service was signed up to the 'Get it right first time' methodology and was starting to audit their services using it. The 'Get it right first time' project was being overseen by the quality management group to review performance and to reduce errors and wastage. The team were reviewing incidents and looking for any trends across the service as a whole. As part of this project the service had begun a get it right first time recognition award, for staff who were working to identify areas for improvement.