Sutton Out-of-Hours GP Service by SELDOC-Urgent Care Centre - St Heliers Hospital

Quality Report

Urgent Care Centre
St Heliers Hospital
Wrythe Lane
Carshalton
Surrey
SM5 1AA
Tel: 020 8299 2619
Website: https://www.seldoc.co.uk

Date of inspection visit: 9 February 2017
Date of publication: 13/06/2017

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

Ratings

Overall rating for this service	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sutton Out-of-Hours GP Service by SELDOC-Urgent Care Centre - St Heliers Hospital on 9 February 2016. Overall the service is rated as requires improvement.

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

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events, although there had been none reported in the last 12 months.
- The service had made no safeguarding referrals in the last 12 months despite issues having been raised. Some staff had not been trained in safeguarding.
- The service could not show how medicines had been audited in the previous eight months.
- 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.
- There was a system in place that enabled staff access to patient records, and the out of hours staff provided other services, for example the local GPs and hospital, with information following contact with patients as was appropriate.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.

Summary of findings

- 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 improvement are:

- Develop effective systems and processes to ensure safe care and treatment including ensuring that all staff are aware of safeguarding policies, are aware of how to make a referral and have undertaken relevant training, and improving medicines management processes and audit the use of medicines.
- Develop governance systems to monitor that safe care is being delivered.

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.

- Staff told us that they understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. However, the service had not raised any serious incidents in the 12 months prior to the inspection.
- All staff seen at the out of hours base were triaged by 111 or accident and emergency staff before being referred to the service.
- There was an effective system in place for recording, reporting and learning from significant events.
- Lessons were shared to make sure action was taken to improve safety in the service.
- When things went wrong patients were informed in keeping with the Duty of Candour. They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the event in the method of communication preferred by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- The out-of-hours service had clearly defined policies and processes and processes in place to keep patients safe and safeguarded from abuse. However, the service had not made any referrals in the past year. This is not in line with a service of this type and size. Furthermore, staff reported having raised safeguarding concerns during this period but these were not documented.
- The service was not able to monitor medicines management in the previous eight months.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- There were systems in place to support staff undertaking home visits.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

Are services effective?

Good

The service is rated as good for providing effective services.

- The service was consistently meeting National Quality Requirements (performance standards) for GP out of hours services to ensure patient needs were met in a timely way.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Clinicians provided urgent care to walk-in patients based on current evidence based guidance.
- 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 the large majority of patients through our comment cards and collected by the provider 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 had good facilities and was well equipped to treat patients and meet their needs.
- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.

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.
- The service was one part of a larger out of hours service based in the south London area.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. However, we notes that the provider had not monitored a lack of referrals for safeguarding or a limited number of significant events at the service.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The service proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

What people who use the service say

As part of our inspection we asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. Twelve of the comment cards we received from patients were wholly positive about the service experienced. They reported that they did not have to wait long and that they were able to resolve their concerns. They also commented that staff were helpful and supportive. Three of the cards said that staff were helpful and courteous but that they had to wait a long time to see a doctor.

We also spoke with four patients during the inspection, although one of the patients had not used the service before and having not seen a doctor was unable to provide feedback. The three that had used the service before reported that they felt that all the staff treated them with respect, listened to and involved them in their treatment. However, one of the patients reported that waiting times could be long. Patients commented that the service was easy to find and that the service had been accessible.

Sutton Out-of-Hours GP Service by SELDOC-Urgent Care Centre - St Heliers Hospital

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Sutton Out-of-Hours GP Service by SELDOC-Urgent Care Centre - St Heliers Hospital

Sutton Out-of-Hours GP Service by SELDOC-Urgent Care Centre - St Heliers Hospital is commissioned to provide a GP out of hours service to Sutton and the surrounding area. SELDOC (the provider) provide out of hours services at 10 sites in south London. The service operates from St Helier Hospital, Wrythe Lane, Carshalton, Surrey, SM5 1AA. During the day the rooms from which the out-of-hours service is based are used for clinics by the hospital Trust. The service is on one level and is accessible to those with limitedmobility.

The service is provided by South East London Doctors Co-Operative (SELDOC). The organisation has two major bases from which management and administration of the services is provided. Each of the sites are registered separately. The provider provides centralised governance for its services which are co-ordinated locally by service managers and senior clinicians.

The service is led by a service manager (who is based at SELDOC's headquarters), and there is a lead GP on site who has oversight of the out of hours service. The service has a limited number of staff working full time at the service. The majority of GPs working at the service were either bank staff (those who are retained on a list of employed staff by the provider and who work across all of their sites) or agency. The site had permanently employed reception staff. The drivers of the cars used by doctors who visit patients were also employed by the service.

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

The urgent care service is open 24 hours a day at weekends and from 6:30pm until 8am during the week. Patients can attend the service without referral, but most patients are referred to the service by NHS 111 services.

Detailed findings

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 9 February 2017. During our visit we:

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the service manager of any incidents and there was a recording form available on the service'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).
- The service had not reported any significant events in the last year.
- The SELDOC service had a newsletter that was sent to GPs working in the service that informed them of any learning from serious incidents at a provider level

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services in place in some areas to keep patients safe and safeguarded from abuse. However, these systems were not consistently used in practice, for example the reporting of safeguarding concerns.. Examples included:

- The service had protocols and policies in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. However, the Sutton site had not made any safeguarding referrals in the 12 months. It is unlikely that a service of this size and type would not have needed to make a safeguarding referral over the course of a year. Furthermore, two reception staff said that they had reported safeguarding concerns to GPs working at the service in the last year. These had not been actioned as safeguarding referrals, and there was no audit trail as to how they had been managed. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Those GPs for whom there was training recorded were trained to child safeguarding level 3. However, seven GPs who worked at the service had no record of having been trained in child safeguarding. Ten GPs had no record of demonstrating competency (e.g. by having undertaken training) in adult safeguarding. Administrative staff were all trained to level 1.
- A notice in the waiting room and in the consulting rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection control lead, although the primary responsibility for infection control on site was the hospital provider whose rooms were being used by the service. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance, for example annual servicing of fridges including calibration where relevant.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment, including for bank and locum staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

- The systems for managing medicines at the service, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal) were safe in some areas but not in others. On the day of the inspection the service was not able to provide medicines audits for the previous eight months. The service had not carried out recent

audits of high risk or antibiotic medicines. The service did not have a system for identifying clinicians who were prescribing higher than expected levels of high risk medicines.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The service held stocks of medicines in a secure location at the hospital site and packs were available to be taken on home visits. However, in some instances there were limited systems to protect patients from harm. For example, adrenaline was carried in two separate concentrations in the medicines packs and there were no systems in place for mitigating the use of the wrong type of adrenaline.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately.

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, the hospital Trust had responsibility for this but this was reviewed by the service manager. 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 and infection control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- There were systems in place to ensure the safety of the out of hours vehicles. The service used a comprehensive checklist which was undertaken by the driver at the beginning of each shift. Records were kept of MOT and servicing requirements. We checked the vehicles and found that they were new and appeared to be in good working condition.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand.
- 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.

Arrangements to deal with emergencies and major incidents

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

- There was an effective system to alert staff to any emergency.
- All staff received annual basic life support training, including use of an automated external defibrillator.
- The 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.
- 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

Management, monitoring and improving outcomes for people

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

Performance for the last six months showed the following:

- The service undertook a monthly review of one per cent of patient contacts in line with National Quality Requirement (NQR) 4.
- NQR 10 requires that providers have systems in place to ensure the following:
- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre with a target of 100%. This target had been met in each of the last six months.
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre with a target of 100%. This target had been met in each of the last six months.
- 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 95%), after the definitive clinical assessment has been completed. In each of the last six months the service had achieved between 98% and 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 six months 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 six months the service had achieved between 95% and 100%.

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

- The service had a quality improvement plan which involved at least one audit per month. This included the following:
- A quarterly audit of formulary adherence.
- A review of all clinicians within three months of them commencing work with the service, including a review of 1% of clinical consultations.
- All clinicians had records reviewed on an annual basis as part of the appraisal process.
- However, there were no recent audits available for monitoring prescriptions of high risk medicines.
- The service participated in local audits, national benchmarking, accreditation and peer review.
- Staff told us that feedback could be provided in one to one sessions, but if there were wider areas for learning these could be shared with the whole team.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

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

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

Coordinating patient care and information sharing

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

- The service shared relevant information with other services in a timely way. Where patients used either of the two services, 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 understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All 15 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the service offered a good service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. The only negative comments made on three of the cards related to waiting times.

We also spoke with three patients on the day of our inspection, and these patients reported that they had been treated with courtesy and dignity. All of the patients we spoke with said they would recommend the service and commented on the excellent service they received. However, one of the patients commented that they had experienced long waiting times.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The service had a hearing loop in place for patients with a hearing impairment.

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 premises were shared with a hospital department which used the consulting rooms during weekdays. The waiting area for patients was in the hallway opposite the consulting rooms. This meant that reception staff could not see patients who were waiting.

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

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

Access to the service

The out of hours service operated from 6:30pm until 8am during the week and 24 hours a day at weekends. Patients could also be referred to the service at times when local GP services were closed due to protected learning time.

Patients accessed the out of hours service through the NHS 111 telephone number. The out of hours service was available for registered patients from all general practices within the local clinical commissioning group area.

Feedback received from patients from the Care Quality Commission comment cards and from the National Quality Requirements scores indicated that in most cases patients were seen in a timely way. Three patients reported that they had to wait a long time but they were not specific about the length of waiting time.

The service had a system in place to assess:

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

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

Listening and learning from concerns and complaints

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

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

We looked at two complaints received in the last 12 months. We saw that in all cases patients received a written response, with details of the Parliamentary Health Service Ombudsman's office provided in case the complaint was not managed to the satisfaction of the patient. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

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

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

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy and good quality care. However, we noted that the provider had not monitored or managed a low number of referrals to safeguarding teams at the location or a low number or reported significant events.:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.
- Staff were not using safeguarding guidance in line with the policy. Specifically, not all staff had been trained in safeguarding and the service had not made referrals in the past twelve months despite us being told that concerns had been raised.
- The provider had a good understanding of their performance against National Quality Requirements. These were discussed at senior management and board level. However, the provider did not effectively monitor whether or not the location was providing safe care.
- 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.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection representatives of the provider demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us that there were clear lines of responsibility and communication. Staff told us that senior managers were approachable although they did not work in the same premises as those at which the service was based.

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

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

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

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

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

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

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

Are services well-led?

Requires improvement

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

- Staff told us that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.
- Staff told us that they were proud of the service being delivered and that they felt engaged in decisions relevant to how the service might be delivered in the future. Staff also told us that the team worked effectively together.

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 service's safeguarding processes did not ensure that they could meet the requirement of this regulation. The service did not document safeguarding concerns and no referrals had been made in the previous 12 months despite two having been raised with clinicians by administrative staff. Staff had not all been trained in child safeguarding. Not all clinical staff had evidence of competency in adult safeguarding. The service's medicines management processes did not ensure that they could meet the requirement of this regulation. 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:** Staff were not using safeguarding guidance in line with the service's policy. Specifically, not all staff had been trained in safeguarding and the service had not made referrals in the past twelve months despite us being told that concerns had been raised. The provider did not effectively monitor whether or not the location was providing safe care.

This section is primarily information for the provider

Requirement notices

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