

PELC Out of Hours Service

Inspection 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 location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Requires improvement 

Overall summary

This service is rated as Good overall (Previous inspection 3,6 and 20 March 2017– Requires Improvement).

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

We carried out an announced comprehensive inspection at Partnership of East London Cooperatives Limited (Out of Hours Service) on 9,10,12 April 2018. Our inspection included a visit to the service's headquarters and also to each of its five base locations.

This inspection was to confirm that the provider had carried out their plan to meet the legal requirements in relation to breaches in regulations that we identified in our previous inspection on 3,6,20 March 2017. At that time the service was rated as requires improvement for safe, effective and well led services; and rated overall as requires improvement. This report covers our findings in relation to those requirements and also in relation to additional improvements made since our last inspection.

At this inspection we found:

- Action had been taken since our last inspection such that medicines management and quality improvement governance arrangements had improved.
- However, we identified new concerns regarding governance arrangements for ensuring that the Hepatitis B status of doctors was kept up to date; and for ensuring that learning from significant events involved all relevant people.

- Action had been taken since our last inspection such that clinical audit was now being used to drive quality improvements.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Patients said that they were treated with compassion, dignity and respect by reception staff and that clinicians involved them in decisions about their care and treatment.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Patients' care needs were assessed and delivered in a timely way according to need. The available data showed that the service consistently met the National Quality Requirements and exceeded the commissioner's performance targets.
- 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 had good facilities and base locations were well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included two GP specialist advisers, a CQC pharmacist specialist adviser, a CQC nurse specialist adviser and a CQC governance specialist adviser.

Background to PELC Out of Hours Service

Partnership of East London Cooperatives (PELC) Limited is a not for profit organisation which was formed in 2004 by a group of GPs who wished to share resources to provide quality out of hours GP services for their local communities. The organisation is a certified social enterprise which reinvests all profits into improving services and communities served. There are no shareholders.

PELC provide GP out of hours services in City & Hackney, Newham, Tower Hamlets, Barking and Dagenham, Redbridge, Havering, Waltham Forest and West Essex Clinical Commissioning Group (CCG) areas to approximately 1.1 million patients.

PELC is also commissioned to provide NHS 111 and urgent care services for this locality (excluding West Essex). The findings of this inspection report relate only to PELC's out of hours service.

The opening hours are seven days a week from 6:30pm to 8am and 24 hours at weekends and bank holidays. Patients access the service via the NHS 111 telephone service. Depending on their needs, patients may be seen by a GP at one of the service's six primary care base locations, receive a telephone consultation or a home visit. The service does not normally accommodate walk in patients.

PELC's primary care base locations are located at:

King George Hospital

Barley Lane

Goodmayes

Essex IG3 8YB

Queens Hospital

Rom Valley Way

Romford

RM7 0AG

Grays Court

John Parker Close

Dagenham

Essex

RM10 9SR

St Margaret's Hospital

The Plain

Epping

CM16 6TN

Wych Elm Clinic

1a Wych Elm

Harlow

CM20 1QP

Uttlesford

The Community Clinic

58 New Street

Dunmow

Essex

CM6 1BH

The service is staffed by a team of 137 whole time equivalent staff, comprising a chief executive officer, a medical director, a head of governance, drivers, nurses and GPs. The service employs sessional (self-employed contractor) GPs directly and occasionally through agencies.

The service's head office is located at:

- Third Floor, Becketts House, 2-14 Ilford Hill, Ilford, Essex, IG1 2FA

The provider is registered to provide two regulated activities:

- Treatment of disease, disorder or injury;
- Transport services, triage and medical advice provided remotely.

Are services safe?

We rated the service as good for providing safe services.

At our previous inspection on 3,6 and 20 March 2017 we rated the practice as requires improvement for providing safe services. This was because the service lacked a proactive approach to managing risks associated with medicines management and infection prevention and control.

When we undertook a follow up inspection on 9, 10, and 12 April 2018, we noted that the provider had improved its medicines management and infection prevention and control protocols, such that the service is now rated as good for providing safe services.

We rated the service as good for providing safe services.

Safety systems and processes

We looked at the systems in place designed to keep people safe and safeguarded from abuse.

- The provider had safety policies, including Control of Substances Hazardous to Health (COSHH) and Health & Safety policies, which were regularly reviewed. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, we noted that the Hepatitis B status of only 56 of the service's 183 doctors was on file.
- Staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. We noted that this requirement had been introduced following our last inspection, which highlighted that DBS checks were not routinely carried out for all staff who acted as chaperones.

- We noted that staff undertaking chaperone duties in the absence of a DBS had been identified as an issue at our last inspection.
- When we inspected in March 2017 we noted the absence of a proactive approach to managing infection risks in that action had not been taken following an Infection Prevention and Control (IPC) audit to ensure that staff received infection prevention and control training. At this inspection, records confirmed staff had received IPC training. We also noted that infection prevention and control audits had taken place within the previous 12 months and actions taken as necessary.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The provider's NHS landlords ensured there were systems in place for safely managing healthcare waste.

Risks to patients

We looked at systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. We also saw evidence of an effective system in place for dealing with surges in demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention such as those at risk of life-threatening illness from Sepsis. Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Information to deliver safe care and treatment

We looked at how staff used information they needed to deliver safe care and treatment to patients.

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

Are services safe?

When we inspected in March 2017, we could not be assured that the service was regularly checking emergency medicines stored at its base locations or in vehicles. We also noted stock control discrepancies regarding medicines taken on home visits. We asked the provider to take action and at this inspection we noted that:

- A chief pharmacist post had been created to support medicines management across base locations and headquarters; and to oversee the activity of the external pharmacy contractor which supplied and monitored the medicines used in the service.
- Arrangements for managing medicines, including medical gases, emergency medicines and equipment minimised risks.
- Emergency medicines, including oxygen, and equipment were available at each primary care centre and for home visits. They were stored securely and there were regular checks in place to ensure these were managed safely. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- Robust processes were in place for checking medicines and staff kept accurate records of medicines. We saw that there were more robust checks on the medicines returned to headquarters after home visits.
- Patient group directives (PGD's) (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation) were used at one location. These complied with all the legal requirements and had been approved by the area prescribing committee.
- We also noted that the temperatures in the medicines stores at the base locations were monitored and recorded daily. These were sometimes above the range recommended for medicines storage, however there was a newly introduced procedure for monitoring the temperature and the pharmacist was supporting the provider to assess the risks and develop an action plan to ensure that the medicines remained safe to use.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- We saw evidence that staff were sent communications about medicines and devices alerts through email and via newsletter but we noted the absence of a system for confirming that these emails had been received and read by recipients.

Lessons learned and improvements made

Although we saw evidence that the provider learned from safety incidents and improved its processes, we could not be assured that learning included all relevant people.

We looked at how the provider shared the learning from significant events and used this information to improve or maintain patient safety. Records showed that in 2017 a new protocol had been introduced whereby any incident which reached a specific threshold was required to be investigated by the provider's Clinical Commissioning Group. We were told that one such event had occurred within the previous 12 months regarding the theft of a blank prescription pad from a base location. Leaders were able to explain how prescription security had been improved so as to minimise the chance of recurrence. However, when we spoke with base GPs, although they confirmed that the new protocol was in place, they were unaware of the significant event which had triggered the new protocol.

We also noted the absence of an effective system for collating and sharing learning from those incidents which were less serious and which therefore did not meet the threshold for a CCG investigation. For example, records showed that the provider produced a quarterly bulletin which shared learning from incidents but some base GPs could not recollect any recent significant events.

Are services effective?

We rated the service as good for providing effective services.

At our previous inspection on 9,10 and 12 March 2017, we rated the service as requires improvement for providing effective services because of an absence of quality improvement activity (such as two cycle clinical audits).

When we undertook a follow up inspection on 5 April 2018. We saw evidence that two cycle clinical audits were now taking place to demonstrate quality improvement. The service is rated as good for providing effective services.

Effective needs assessment, care and treatment

The provider had some systems in place to keep clinicians up to date with current evidence based practice (for example a GP forum and a regular newsletter). We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and we were told used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed through the use of clinical audit.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

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 face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

- For the period April 2017 to March 2018, the provider's performance regarding starting base urgent or less urgent consultations respectively within one hour, two hours or six hours ranged between 96% - 100% for its Goodmayes, Dagenham, Romford and Epping locations. The commissioners' performance target was 95%.
- For the period October 2017 to March 2018, the provider's performance regarding starting base urgent or less urgent consultations respectively within one hour, two hours or six hours ranged between 96% - 100% for its Harlow and Dunmow locations. The commissioners' performance target was 95%.

When we inspected in March 2017, two clinical audits had commenced but not been completed. The provider could not demonstrate therefore how clinical audits were used to drive quality improvement. We asked the provider to take action.

At this inspection, we noted that the provider had introduced a 2018/19 Clinical Audit Plan and that audits were being routinely used to drive improvements. Four complete clinical audits had taken place within the previous 12 months and we noted that they were clinically relevant to an urgent care setting. We also saw evidence of how they had positively impacted on quality of care and outcomes for patients.

For example, in May 2017, the service audited compliance with local antibiotic prescribing guidelines. The first cycle highlighted that of the 35 cases reviewed 2 cases (6%) had prescribed antibiotics appropriately. Following discussion at a GP forum, audit group meetings and also the uploading of guidelines to all base computer desktops, a September 2017 re-audit highlighted that 14 (66%) of the 21 cases audited demonstrated appropriate prescribing. We did not see evidence, however, of subsequent actions or reaudits to further drive improvements.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The provider had an induction programme for all newly appointed staff and which covered such topics as safeguarding.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.

Are services effective?

- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained and staff were encouraged and given opportunities to develop.
- The provider provided staff with ongoing support. This included one-to-one meetings, coaching and mentoring, appraisal, clinical supervision and support for revalidation.

Coordinating care and treatment

Staff worked together, and worked well with other organisations to deliver effective care and treatment.

- Staff communicated promptly with patients' registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support such as those for whom English was not their first language.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- We saw evidence that risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.
- The majority of the 45 patient Care Quality Commission comment cards we received were highly positive about the service experienced. This aligned with patient survey data collected between April 2017 and November 2017 which showed that 238 (89%) of the 266 patients surveyed were either "extremely likely" or "likely" to recommend the service to their friends or family.
- When we spoke with base reception staff they stressed the importance of treating patients with respect, compassion and dignity.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices

in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.

- Patients told us through comment cards, that 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.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The service worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. We found the service was responsive to patients' needs. For example, the provider was also commissioned to provide an urgent care service from one of its five base locations.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered. For example, accessible facilities and baby changing equipment.
- The service made reasonable adjustments when people found it hard to access the service.
- Consultations were not restricted to a specific timeframe so clinicians were able to see patients as long as was necessary.
- All base locations offered step free access and were accessible to patients with reduced mobility.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients could access the out of hours service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.

Patients had timely access to initial assessment, test results, diagnosis and treatment.

- For the period April 2017 to March 2018, the provider's performance regarding conducting urgent and less

urgent home visits respectively within two and six hours ranged between 91% - 100% for its Goodmayes, Dagenham, Romford and Epping locations. The commissioners' performance target was 95%.

- For the period January 2018 to March 2018, the provider's performance regarding conducting urgent and less urgent home visits respectively within two and six hours ranged between 90% - 100% for its Harlow and Dunmow locations. The commissioners' performance target was 95%.
- For the period January 2018 to March 2018, the provider's performance regarding conducting urgent telephone clinical assessments within 20 minutes ranged between 87% - 97% for its Goodmayes, Dagenham, Romford and Epping locations. The commissioners' performance target was 95%.
- For the period January 2018 to March 2018, the provider's performance regarding conducting urgent telephone clinical assessments within 20 minutes ranged between 85% - 93% for its Harlow and Dunmow locations. The commissioners' performance target was 95%.
- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited.
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs. For example, the patient's own GP or a local pharmacist.

Listening and learning from concerns and complaints

We looked at how complaints and concerns were used to improve the quality of care.

- Information about how to make a complaint or raise concerns was available.
- The complaint policy and procedures were in line with recognised guidance. Fourteen complaints had been

Are services responsive to people's needs?

received between May 2017 and March 2018 (ninety three complaints for the combined UCC, 111, out of hours services). We found that complaints were satisfactorily handled in a timely way.

The service also learned lessons from individual concerns and complaints; and from an analysis of trends at monthly operational meetings.

Are services well-led?

We rated the service as requires improvement for leadership.

At our previous inspection in March 2017, we rated the service as requires improvement for providing leadership because governance arrangements relating to medicines management and quality improvement did not always operate effectively.

When we undertook a follow up inspection on 9, 10 and 12 April 2018, we saw evidence that governance arrangements in these areas had improved but noted new concerns regarding governance arrangements for ensuring that the Hepatitis B status of doctors was kept up to date; and for ensuring that learning from significant events involved all relevant people. The service is rated as requires improvement for providing well led services.

Leadership capacity and capability

- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.

Vision and strategy

We were told that the service had a clear vision to create a health care system that provided clinical excellence, patient-focussed and centred, culturally competent, cost effective care with exceptional outcomes and patient satisfaction.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with integrated urgent care priorities across the region. The provider worked with commissioners to meet the needs of the local population.

Culture

We looked at the culture of the service:

- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- The service aimed to focus on the needs of patients.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were positive relationships between staff and teams.

Governance arrangements

When we inspected in March 2017 governance arrangements did not always operate effectively in that medicines management protocols did not ensure that emergency medicines were readily available and in that clinical audits were not being used to drive quality improvements. We asked the provider to take action and at this inspection we noted:

- A Clinical Audit Plan had been introduced listing audits which were clinically relevant to an urgent care setting and which had positively impacted on quality of care and outcomes for patients.
- A chief pharmacist had been appointed and had introduced clear responsibilities, roles and systems of accountability to support the appropriate and safe handling of medicines.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned and improved its processes but this learning did not always involve all relevant people.

We noted an absence of appropriate governance arrangements to ensure that the Hepatitis B status of doctors was on file. Also, although we saw evidence that staff were sent communications about medicines and devices alerts through email and via newsletter, we noted the absence of a system for confirming that these emails had been received and read by recipients. In addition, although clinical audit had a demonstrable impact on quality of care and outcomes for patients, we did not see evidence of actions taken to drive further improvements in one of the four completed audits we reviewed.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Are services well-led?

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of incidents and complaints.
- Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients' views were encouraged, heard and acted on to shape services and culture.
- Staff were able to describe to us the systems in place to give feedback.
- For example, staff who worked remotely told us they felt engaged and were able to provide feedback through their line manager.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have appropriate governance systems in place to ensure that learning from significant events included all relevant people; to effectively monitor the Hepatitis B status of its doctors or to confirm that medicines and devices email alerts had been received and read by recipients. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.