SELDOC OOHs at St Georges Hospital

Quality Report

St George's Hospital
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Date of inspection visit: 17 August 2017
Date of publication: 17/10/2017

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	Good
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?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the SELDOC Out of Hours Service at St George's Hospital on 17 August 2017. Overall the service is rated as good.

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

- The arrangements for managing medicines at the service did not always keep patients safe. Medicines audits had been introduced but were not yet completed, with one cycle being carried out, and as such did not demonstrate actions identified had been implemented or were effective in making improvements in prescribing and medicines management. The provider did not record the dispensing of medicines in line with guidelines.
- The service did not carry medical gases such as Oxygen, or an Automatic External Defibrillator (AED) in vehicles used for home visits and did not have a documented risk assessment mitigating their absence.
- There were clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse.
- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Patients' care needs were assessed and delivered in line with current evidence based guidance and in a timely way according to need. The service met the National Quality Requirements.
- 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 had good facilities and was well equipped to treat patients and meet their needs.

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:

- Ensure care and treatment is provided in a safe way for service users; including the proper and safe management of medicines and assessing the risk of not providing Oxygen and Automatic External Defibrillator on service vehicles used for home visits and, where appropriate, mitigating their absence.

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.

- The arrangements for managing medicines at the service did not always keep patients safe. Medicines audits had been introduced but were not yet completed, with one cycle being carried out, and as such did not demonstrate actions identified had been implemented or were effective in making improvements in prescribing and medicines management. The provider did not record the dispensing of medicines in line with guidelines.
- The service did not carry medical gases such as Oxygen, or an Automatic External Defibrillator (AED) in vehicles used for home visits and did not have a documented risk assessment mitigating their absence.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- 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 preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- The service had clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse.
- When potentially vulnerable 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 them up.
- 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.

Are services effective?

Good

The service is rated as good for providing effective services.

Summary of findings

- 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 of GP performance against standards and guidelines 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.
- 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 patients through our comment cards and collected by the provider was 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.
- 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.

Summary of findings

Are services well-led?

Good

The service is rated as good 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.
- 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. This included arrangements to monitor and improve quality and identify risk.
- The service had identified and responded to concerns raised around monitoring and prescribing of medicines in the service; however, improvements had not yet been fully implemented and their effectiveness assessed.
- 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.

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. We received 11 comment cards which were all positive about the service provided. Patient comments included that staff were nice and friendly, that they felt listened to, and that the service was quick and efficient.

We were not able to speak with any patients during our inspection.

SELDOC OOHs at St Georges Hospital

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection to the provider headquarters was led by a Care Quality Commission Lead Inspector**.** The team also included a GP specialist adviser, a practice manager specialist adviser and a second CQC inspector.

The inspection team for the out of hours service at St George's Hospital comprised a CQC Lead Inspector and a GP specialist adviser.

Background to SELDOC OOHs at St Georges Hospital

South East Doctors Cooperative Limited (SELDOC, the provider) is commissioned to provide a range of GP out of hours services in south London. SELDOC provides centralised governance for its services from two main administrative locations. Governance arrangements are co-ordinated locally by service managers and senior clinicians for each of the ten service locations, including the service provided from St George's Hospital.

SELDOC Out of Hours service at St George's Hospital is provided from within a department of St George's Hospital, Blackshaw Road, Tooting, London, SW17 0QT. There is a reception desk, waiting area and the provider uses two consultation rooms to see patients. The out of hours service operates with two GPs and one receptionist on site. Patients have access to toilet facilities and seats in the waiting area. The service is on one level and is accessible to those with poor mobility.

The service is open between 6.30pm and Midnight Monday to Friday, and between 10am and Midnight on weekends and bank holidays. Patients can only attend the service with referral through the NHS 111 service. On average the service sees 246 patients per week.

The service is led by a service manager (who is based at SELDOC's headquarters), and there is a GP on site who has oversight of the out of hours service. Team Leaders are also available via telephone at the service headquarters to address any problems staff may face.

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 part time reception staff.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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 also visited the provider headquarters on 3 August as part of our inspection of another of the providrs locations. Information collected during that inspection is used in this report. We carried out an announced visit of the service operated from St George's Hospital on 17 August 2017. During our visit we:

- Spoke with a range of staff (including the duty GPs, a service manager, deputy medical director and the duty receptionist) and spoke with patients who used the service.
- Observed how patients were provided with care.
- Inspected the areas of the premises used by the service, including cleanliness and the arrangements in place to manage risks to staff and service users.
- 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 computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- The service carried out a thorough analysis of significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes.
- The SELDOC service had a weekly bulletin and monthly newsletter that was sent to GPs working in the service that informed them of any learning from serious incidents.

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. 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. There was a safeguarding referral system in place including a referral form on the service computer system. There was a lead member of staff and deputy for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The Medical director and Deputy Medical Director had received training to level 5, GPs were trained to child safeguarding level 3, and non-clinical staff were trained to level 1.
- A notice in the waiting room and in the consulting room 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 areas used by the service to be clean and tidy, as were other areas we saw during our visit. There was an infection control protocol in place and staff had received up to date training. 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. 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 calibration of diagnostic equipment.
- We reviewed nine personnel files for staff working across the service, including at this location, and found appropriate recruitment checks had been undertaken prior to employment, including for bank and agency 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 arrangements for managing medicines at the service, including emergency medicines did not always keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).
- The provider had a range of appropriate policies, procedures and guidance accessible by staff. These were regularly reviewed and met local and national guidance.

Requires improvement

Are services safe?

- Information provided ahead of this inspection demonstrated the service had carried out recent medicines audits between January and March 2017 for the whole service to ensure prescribing was in accordance with best practice guidelines for safe prescribing. These audits were not completed, with one cycle being carried out, and as such did not demonstrate actions identified had been implemented or were effective in making improvements in prescribing and medicines management. We did see examples of individual GPs who had been contacted for feedback on their own high prescribing rates and were reminded of the service prescribing policies and procedures.
- Blank prescription forms were securely stored in the out of hours service and there were systems in place to monitor their use.
- The service did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles. Medicines were kept in cassettes which were sealed at the point of packaging. Cassettes were delivered to and collected from sites on a regular basis and as required. Cassettes carried an appropriate range of medicines based on the needs of patients using the service. Additional medicines were accessed through local pharmacies by patients if required. The service did not have an appropriate system for recording and auditing medicines dispensed from cassettes on home visits or from out of hours locations. The service recorded if medicines were dispensed on a check sheet that stayed with the cassette rather than using the appropriate prescription recording form as is required. The provider had recently reviewed this system and had procured the necessary prescriptions forms but had not yet implemented training and delivery of the improved system.
- Arrangements were in place to ensure medicines carried in the out of hours vehicles were stored appropriately.

Monitoring risks to patients

Risks to service users and staff were assessed and well managed.

- There were procedures in place for monitoring and managing risks to service user and staff safety. There was a health and safety policy available. The service manager, in conjunction with the building owners and operators, had up to date fire risk assessments and took part in regular fire drills and alarm tests for the site. All electrical equipment was checked to ensure the equipment was safe to use by the hospital operators. Clinical equipment used by the out of hours service was held separately and was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. The site operators 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 (bacteria which can contaminate water systems in buildings) which the service were involved in.
- There were systems in place to ensure the safety of the out of hours vehicles operated from the provider headquarters. 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 clean, tidy 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.

Requires improvement

Are services safe?

- 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 access to a defibrillator and oxygen with adult and children's masks on the premises. The service did not carry medical gases such as Oxygen, or an Automatic External Defibrillator (AED) in its vehicles and did not have a documented risk assessment mitigating their absence.
- 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 key staff and contractors.

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 between October 2016 and June 2017 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 9 requires providers to ensure that definitive clinical assessment for urgent calls is started within 20 minutes and other calls within 60 minutes of the call being answered by a person, with a target of 95% for both indicators. The provider achieved an overall performance rate of 94% for this standard, with multiple breaches over the period. The provider had identified their low performance and put in place an investigation and action plan which included working with the provider of call handling services and the provider of the computer software used to collect the data to improve data management and reflect improved performance.
- 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 and 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 nine 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 nine months the service had achieved 100%.
- Face-to-face consultations (whether in a centre or in the patient's place of residence) of urgent patients must be started within two hours (with a target time of 95%), after the definitive clinical assessment has been completed. In the last nine months the service had achieved between 96% 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 six hours (with a target of 95%), after the definitive clinical assessment has been completed. In the last nine months the service had achieved between 96% 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.

There was evidence of quality monitoring and improvement through clinical audit;

- The service conducted a review of 1% of clinical consultations. This included all clinicians being audited within one month of them commencing work with the service, and an ongoing monthly audit of GP consultations. Consultation audits included face to face consultations and telephone consultations.
- GPs receive quarterly audit score feedback and we saw evidence that where standards fall below the 80% pass mark, the GP's performance is managed in line with the service policy. For example a GP whose audit scored 63% due to clinical note taking not meeting the required

Good

Are services effective?

(for example, treatment is effective)

standard had this information fed back to them by the medical director. Subsequent audit scores were consistently above the 80% pass mark for this GP. There were also examples provided of clinicians whose audit performance had not improved over time and whose contracts were ended.

- Audit feedback was provided via email, telephone call, in one to one sessions or performance review meetings, but if there were wider areas for learning these would be shared with the whole team through email bulletins and newsletters.

Effective staffing

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.
- 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. Mandatory training requirements for all staff were monitored centrally, with clinicians not being selected for clinical shifts if their mandatory training was not up to date and we saw examples of this system working.
- 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.

- This included access to required special notes which detailed information provided by the person's GP. This helped the out of hours staff in understanding a person's needs.
- The service shared relevant information with other services in a timely way, for example by sending out of hours notes to the registered GP services electronically by 8am the next morning.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients using the out of hours service.
- The provider worked collaboratively with other services.
- Patients who could be more appropriately seen by their registered GP were referred.
- We saw evidence that patients presenting with emergency conditions were treated and stabilised before being transferred to the care of the ambulance 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.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received was positive and demonstrated staff felt listened to, treated with dignity and respect, and that they had their needs met quickly.

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.
- Information leaflets were available to be printed in easy read format and in a range of languages if required.
- The service had use of a hearing loop 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 when their own GP practice was closed.

The premises were shared with a hospital minor injuries unit which used the consulting room during the day for GP consultations which were contracted separately through a different provider.

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

- Home visits were available for patients whose clinical needs which resulted in difficulty attending the service.
- 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.
- All areas to the service were accessible to patients with poor mobility.
- 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 service was open between 6.30pm and Midnight Monday to Friday, and between 10am and Midnight on weekends and bank holidays. Patients could only attend the service with referral through the NHS 111 service. 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 patients were seen in a timely way.

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 available on the service website.

We looked at eight 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. We saw evidence learning was shared in the service newsletters and weekly bulletins.

Are services well-led?

Good

(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. This outlined the structures and procedures in place and ensured that:

- 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; however, some policies and procedures were not effective in ensuring safe care and treatment.
- The provider had a good understanding of their performance against National Quality Requirements. These were discussed at senior management and board level.
- Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements, and the service had identified and responded to concerns raised around monitoring and prescribing of medicines in the service; however improvements had not yet been fully implemented and their effectiveness assessed through reaudit.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection 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. Reception staff told us that team leaders were always available on the telephone for checking in at the start and end of shift and for managing queries and issues that may arise. Service managers would make unannounced and announced visits to services and location specific performance was monitored centrally through data analysis.

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; however non-clinical staff did not have the same level of information relevant to their role.
- 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.

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

Are services well-led?

Good

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

- Quarterly patient satisfaction questionnaires were carried out at all of the out of hours locations and we saw evidence that patient satisfaction was high.
- The provider also collected patient satisfaction information in conjunction with the local NHS 111 service satisfaction questionnaires. This information also showed high satisfaction levels with the out of hours service.
- We saw evidence feedback from patients was investigated and that learning was shared with staff through workshops and training updates.
- 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.

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:** Care and treatment was not provided in a safe way for service users; • The provider did not ensure the proper and safe management of medicines. • The provider did not assess the risk of not providing Oxygen and Automatic External Defibrillator on service vehicles used for home visits or mitigate their absence. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.