SELDOC Base - Dulwich Community Hospital

Quality Report

East Dulwich Community Hospital
East Dulwich Grove, London, SE22 8PT
Tel: 020 8299 2619
Website: seldoc.enquiries@nhs.net

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
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 at South East London Doctors' Cooperative (SELDOC) Ltd Dulwich on 20th and 21st January 2015. Overall the provider is rated as good.

Specifically, we found the provider to be good for providing safe, effective, caring, responsive and well led services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The service used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example they provided medical input to the local at home service to avoid admissions and worked with the ambulance service to reduce admissions to hospital for category C calls.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The service implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients
- The service had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand

The service had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all staff with evidence of team working across all roles.

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?

Good

The service is rated as good for providing safe services. Staff at all levels understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The service is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving service and outcomes for patients. Data showed that the service was performing well with their national quality requirements (NQRs). Staff were supported with a comprehensive programme of training and systems were in place to ensure training needs were identified and planned for. The service was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. They provided medical input to the local “at home service” for admissions avoidance and also in conjunction with the London ambulance service reduced the number of people attending/ being admitted to hospital.

Are services caring?

Good

The service is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Patients confirmed they were treated in privacy and we observed that consultation doors were always closed when patients were being seen and conversations could not be overheard.

Are services responsive to people’s needs?

Good

The service is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with stakeholders to secure improvements to services where these were identified. Patients said they found it easy to get through on the

Summary of findings

telephone and if offered an appointment they were seen promptly. The service had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place.

Are services well-led?

Good

The service is rated as good for being well-led. The service had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The service gathered feedback from patients and used it to improve the service.

Summary of findings

What people who use the service say

We received seven completed CQC comment cards and spoke with three patients during the inspection. Generally patients were happy with the service they received. Patients described staff as helpful and caring. They were all complimentary about staff and the care they received.

All the patients we spoke with who attended the service said it was never difficult to get through to the call handlers and that they were offered an appointment and seen at or before their appointment time.

SELDOC Base - Dulwich Community 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 included a second CQC Inspector and a GP Specialist advisor. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to SELDOC Base - Dulwich Community Hospital

South East London Doctors Cooperative (SELDOC) Ltd is based in East Dulwich Community Hospital in London. It consists of local GPs from practices across Lambeth, Southwark and Lewisham. The members of the GP co-operative remain opted in to the provision of out of hours services. Since November 2013 SELDOC has also been running the Sutton out-of-hours service. SELDOC has 129 GP practices who are members of the co-operative. Patient population for Lambeth, Southwark and Lewisham is approximately 900,000 and a further 180,000 in Sutton.

SELDOC currently has four active locations. These are SELDOC Base Dulwich Community Hospital, Gracefield Gardens, University Hospital Lewisham – Urgent Care Centre and Sutton out-of-hours GP service based at St Helier Hospital in Sutton. SELDOC are registered to provide two regulated activities; Transport services, triage and medical advice provided remotely; Treatment of disease, disorder and injury. We only visited the SELDOC Base Dulwich Community Hospital as part of this inspection.

The facility at the Dulwich base includes four consulting rooms, call centre, reception area and two general administration offices. There are approximately 120 duty GPs from Lambeth, Southwark and Lewisham and a further 32 who cover Sutton. Demand for the service has steadily increased over the months with the provider providing 1217 rota sessions in December 2014 as compared to 927 in January 2014.

SELDOC was previously inspected in February 2014 under the new CQC inspection programme. This inspection was carried out in order to give the service a rating under the new inspection programme.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme for out-of-hours emergency cover for GP services.

How we carried out this inspection

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?

Detailed findings

Before visiting, we reviewed a range of information submitted by the provider including information relating to staffing, policies and procedures, complaints and serious incidents. Unfortunately we did not hold any intelligence monitoring information about this service, at the time of the inspection. The provider did not have a profile on NHS Choices and no CQC share your experiences web forms had been completed.

We carried out an announced visit on 20 and 21 January 2015 starting at 4.45pm on the 20th and concluding at 12.30am on the 21 January 2015. As part of the inspection process we spoke with a broad range of clinical and non-clinical staff including GP', directors and call handlers. We also spoke with patients and reviewed information such as policies and procedures and records. We observed how people were being cared for and reviewed patient comment cards.

Are services safe?

Our findings

Safe track record

There were processes in place to ensure safety was monitored over time. There were procedures for reporting concerns and staff were encouraged to raise any concerns they had. The provider had an incident reporting procedure which was last updated in July 2014. Near misses were recorded as incidents and a separate record maintained. All incidents were presented in the quarterly SELDOC performance report. This report also went to the clinical governance committee for scrutiny. An annual quality report was also produced and reviewed by the clinical governance committee. Serious incidents were included in this report including outlining the investigations findings, learning points and current status of the incident.

Learning and improvement from safety incidents

The service had a system in place for reporting, recording and monitoring serious adverse events. We saw evidence that every opportunity was used to learn from internal and external incidents. This included presenting and discussing incidents at all levels throughout the organisation (staff meetings to committee and scrutiny meetings), reminding staff about safety and sharing lessons learnt through newsletters and posters in the staff room.

The provider maintained a log of all serious adverse events (SAE). There had been two serious events over the past 12 months. One related to an administration error which led to a patient not being triaged appropriately. The other related to a delayed diagnosis. The medical director told us that learning from serious adverse events was part of the root-cause analysis they undertook. We saw that each case was risk assessed, action taken was detailed, lessons learnt were documented and feedback to improve safety in the service was disseminated to staff. The provider had processes in place to update staff about incidents and make them aware of lessons learnt. This included posting bulletins in the staff room, including details about the incident and lessons learnt in a quarterly newsletter and discussing as an agenda item at regular clinical meeting.

There was evidence that the service had learned from these events and that the findings were shared with relevant staff. For example an incident related to a failed contact was published in the services' staff newsletter. As a result of the incident the failed contact procedure was changed to minimise the risks of a similar incident re-occurring. Staff, including call handlers and administration staff, knew how to raise an issue for consideration and they told us they were encouraged to do so. A member of the administration staff team told us that staff were always informed (usually by an email alert) if something went wrong, even if it did not relate to their area of work but could have a potential impact upon it.

We saw evidence of action taken as a result, for example we saw that as a result of an incident a blood result log had been created so that blood results were acknowledged, and reviewed and subsequent actions taken. Staff told us that when patients had been affected by something that had gone wrong, in line with the service policy, they were involved in the investigation by interview, given a written and verbal apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The service had systems to manage and review risks to vulnerable children, young people and adults. The service had up to date policies and procedures for protecting both children and adults from harm. The medical director was the designated lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the service if they had a safeguarding concern.

Child protection and safeguarding adults was part of mandatory training for all staff. All the GPs who worked in the service, had completed level three child protection training and also undergone safeguarding adults training. Non-clinical staff had also completed safeguarding adults training and level one child protection. Staff knew how to recognise signs of abuse in older people. Vulnerable adults and children and were able to describe the organisation's procedures for reporting safeguarding issues. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details of external agencies were easily accessible.

There was a chaperone policy, which was visible on the waiting room noticeboard and on all consulting room doors advising patients of their right to have a chaperone if

they needed an examination during a consultation. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The GPs told us they always told patients their rights and offered a chaperone if relevant. Non-clinical staff confirmed they were used to chaperone and had received chaperone training. Disclosure and Barring services checks were in place for all non-clinical staff. They told us that the GPs always explained their role and made sure they were comfortable being present during the examination.

There was a system to highlight vulnerable patients who attended the out of hours' service. The service was a co-operative of local GPs and as a result all GPs in the co-op uploaded details of all their vulnerable patients (special patient notes) directly onto the service's system. There were systems in place for the GP practices to update the service when their list of vulnerable patients changed. Staff were alerted when any vulnerable patient registered on the database contacted the service.

If reception staff or call handlers identified a patient as vulnerable or had concerns about a patient who did not have a flag against their record, the concern was documented and the GP due to speak with or see the patient was alerted.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The staff followed the policy. The fridge had an internal alarm and the temperature was checked twice a day to make sure it was within the required range of between 2-8 degrees Celsius. All readings were recorded in a central log.

Processes were in place to check medicines were within their expiry date and suitable for use. Each item had an individual monitoring sheet that recorded the expiry date, batch number, date in and out and the patient case number. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The service held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place a policy and procedures that set out how they were managed. The policy outlined the legal, ethical and good practice guidance for prescribing, key principles to consider, clinical conditions and prescribing and record keeping. This procedure for checks included carrying out three daily checks, maintaining a controlled drugs book and completing a balance check log to make sure all drugs were accounted for. These were being followed by staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. The pharmacist oversaw the destruction of controlled drugs and the service had the appropriate authority through a T28 exemption certificate which was in place to do this. [A T28 exemption certificate is granted under the Misuse of Drugs regulation 2001 and allows appropriate persons to dispose of controlled drugs.]

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the result.

The service produced an annual medicines management report that analysed prescribing costs and trends. The report analysed the trends by therapeutic areas such as infections, respiratory system, skin and nutrition and blood. The report highlighted their key objectives for the year ahead.

Staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

We observed the premises to be clean and tidy. The landlord was responsible for cleaning the premises and the provider had copies of the cleaning schedules and was aware of what should be carried out. Patients we spoke with told us they always found the premises clean and had no concerns about cleanliness or infection control.

The medical director was the lead for infection control. Infection control training was mandatory for all staff and repeated annually. We saw records to confirm this. We saw evidence that the lead had carried out audits for each of

the last three years and that any improvements identified for action were completed on time. Minutes of clinical and staff meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. The infection control policy was last updated in August 2014.

Notices about hand hygiene techniques were displayed in the staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The provider had access to a copy of the landlord's most recent Legionella risk assessment (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had the required equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date in August 2014. A schedule of annual testing was in place. We saw evidence of calibration of relevant equipment; for example baby scales, defibrillator, pulse oximeter and blood pressure measuring devices and the fridge thermometer; being carried out in August 2014.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The service had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed staff files which had all relevant documents in line with their procedures. The service used a small number of locum GPs and they were subject to the same recruitment checks as permanent GPs. The provider had processes in place to verify the recruitment checks that the agencies had carried out prior to any locum commencing work.

The medical director told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The operations team looked at the rotas weekly to ensure sufficient staffing. Examples of the impact this planning had was that they were able to adjust Saturday and Sunday morning staffing patterns to better meet the needs of people who used the service. In addition the number of rota sessions for locums had increased significantly over the past year from 2% to 6%. Staff explained that the rise was due to an increase in demand for the service. We saw that the service made adjustments to staffing levels according to seasonal fluctuations. For example the service was historically busy over Christmas so staffing rotas for GPs and call handlers was adjusted to deal with the increase in demand for the service.

Staff told us there were usually enough staff to maintain the smooth running of the service and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The provider had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the service. These included annual and monthly checks of the environment, medicines management, staffing, dealing with emergencies and equipment. The service also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at staff meetings and information disseminated through the quarterly newsletter. For example, we saw the January 2015 newsletter had an article about safeguarding with three different case scenarios. One related to children

most at risk and another to an adult with dementia. The article explained staff responsibility, the process of referral to social services and other multi-disciplinary teams that should be contacted.

Arrangements to deal with emergencies and major incidents

The service had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support and it was repeated annually as part of mandatory training. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the service and all staff knew of their location. These included those for the treatment of cardiac emergencies, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the service. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The provider had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of meetings where new guidelines were disseminated, the implications for the service's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The service used special patient notes, uploaded from all the GP practices in the co-operative so that they could identify patients with complex needs who had multidisciplinary care plans documented in their local GP case notes.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the service was that patients were cared for and treated based on need and the provider took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

There were National Quality Requirements (NQR) for out-of-hours providers. These were used to show the service was safe, clinically effective and responsive. Providers were required to report monthly to the Clinical Commissioning Group on their performance against standards which included 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. We reviewed the reports for August 2014 to December 2014. We saw that the service was generally meeting their targets from August to November with only two breaches over the five month period. December reporting showed that the service did not meet all NQR targets including, answering calls within 60 seconds (target of 95% but 82% achieved), and clinicians making routine calls within 60 minutes (target of 95% but 84% achieved). The operations manager explained that December was traditionally a busier time and although they planned ahead for the increased demand in the service this year they had a 69% increase in demand which was unprecedented.

The results of NQRs were reviewed at the quarterly staff meetings. We saw that the monitoring of NQRs led to improving outcomes for people. For example, a review of the NQR relating to staffing had led to an increase in staffing hours for the weekends.

Effective staffing

Staffing included medical, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, health and safety, adult safeguarding and equality and diversity. The service was proactive in encouraging staff to complete mandatory training. Notices were displayed in the call centre reminding staff to complete outstanding mandatory training, managers were emailed and statistics of people who had completed/ not-completed training were discussed in team meetings and during staff appraisals if applicable.

All staff had personal training records which were updated on a continuing basis. Staff had an individual login to the training system and there was a non-compliance record if staff had training that was outstanding. Human resources could produce reports to see which member of staff had training outstanding and would contact them if they found any non-compliance.

The majority of training was via e-learning. All staff were given a disk containing all relevant courses so that they could complete training at home. The operations manager told us that this gave staff the freedom to complete training in a flexible manner. Staff received a certificate when they had completed the training and a copy of the certificate was emailed to their manager so they could track and monitor training staff were completing.

All staff received a copy of "The SELDOC way". This was a document that outlined the service's vision and aims, detailed information for call handlers to be effective in their role (including a script of the ideal conversation), the staff

Are services effective?

(for example, treatment is effective)

induction checklist, staff performance criteria and staff impact on the NQRs. Staff spoke very positively about the handbook and told us it was a good tool to ensure they always maintained high standards.

The provider had devised a doctor performance report. The report was completed monthly and recorded the number of calls a GP took, average time spent on each consultation, prescribing behaviour and complaints and compliments. This enabled the provider to identify themes and trends amongst individual GPs and collectively. If GPs scored below a certain number or if something was highlighted as a result of the report the medical director would carry out a one to one with the GP to discuss the area that needed improving. This system was also in place for temporary and locum staff. The medical director told us that they found this auditing useful to ensure staff were effective and performing consistently. For example, the audit helped them to identify when agency workers were performing poorly and they were able to stop using them.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example call handlers told us that a range of learning and development opportunities were available to them in addition to the mandatory training.

Working with colleagues and other services

The service worked with other service providers to meet patients' needs and manage patients with complex needs. It sent out-of-hours notes to the registered GP services electronically by 8am the next morning. The service had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The service provided the medical staff, including nurses to an "at home" service for admissions avoidance. They worked with a local hospital to provide a visiting service to mainly elderly frail patients in their home to avoid their admittance to hospital. If the ambulance service attended a call out and felt a GP would be best suited to attend they would transfer the call to the "at home" service and a SELDOC GP attended to visit the patient. The operations manager told us that this service had a high success rate and since the start of the service no patients had been admitted to hospital. A team of GPs and nurses carried out visits to patients and performed duties such as checking blood results and putting up drips. If a nurse visited a patient during out of hours times and they needed a GP they would call a SELDOC GP to attend.

The service was part of a pilot scheme and provided a support service to the ambulance service attending category C calls. Category C calls are regarded as non-serious or life threatening calls. Category C ambulance call outs were diverted to the out-of hours and a GP attended in a car assess the patient. Statistics showed that 90% of calls the ambulance attended resulted in the patient being admitted to hospital as opposed to 12% of calls responded to by the GPs from the out of hours. The operations manager told us that this arrangement was working well to produce positive outcomes for patients.

The out-of –hours service was the contingency arrangements for all 129 GP practices in the co-operative. If any of the practice experienced an emergency such as power failure or flood all calls for the affected practice were directed to SELDOC lines and patients triaged appropriately.

Information sharing

The service used several electronic systems to communicate with other providers. For example, there was a shared system with all the GPs in the co-operative to enable patient data to be shared in a secure and timely manner.

In line with their reporting requirements the provider had arrangements in place to ensure data about patients they

Are services effective?

(for example, treatment is effective)

saw was with the patients practice by 8am the following morning. The system was set up so that all patient alerts from NHS England and special notes were saved automatically.

The service had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the service had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The service had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

We saw patient information leaflets in the waiting and consulting rooms relating to health promotion. GPs we spoke with confirmed they discussed health promotion with patients when relevant and appropriate. However they also advised patients to follow things up with their own GP for further and more detailed information. Patients' smoking status was recorded and information about smoking cessation, healthy lifestyles and exercise was given to patients.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the service. We received seven completed cards and the majority were positive about the service experienced. Patients said they felt the service offered a good service and staff were polite, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive and related to an isolated incident. We also spoke with two patients and one relative on the day of our inspection. All told us they were satisfied with the care provided by the service and said their dignity and privacy was respected. They said that access to the service was very good and confirmed that waiting times were within what they would have expected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Call handlers wore headsets to speak with patients. All call handlers sat in the same area and took calls from patients. We heard staff being polite and respectful to patients. Staff we spoke with gave examples of when they had received a call from a patient and had to show empathy and compassion. The service provided call handlers with a script of things to consider when speaking with patients. For example there were prompts for what to say if a patient was particularly distressed and in a crisis management situation.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with one of the managers. The medical director told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the service's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us that the GP gave appropriate information and advice about the issue they visited for. One person told us that the GP had completed a good assessment of their needs and given good advice so they understood their treatment. They also told us they felt listened to and supported by staff and had sufficient time during consultations and the telephone conversation to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Call handlers told us that often people on calls were anxious and worried about a family member who they were calling on behalf of. They explained how they provided empathy and care when dealing with patients and relatives. The patients we spoke with on the day of our inspection and the comment cards we received confirmed that staff provided appropriate support to cope emotionally with care and treatment. One person explained that their child had been a patient at the service before and staff had dealt with them appropriately and given appropriate information to help their child understand their treatment and cope with the pain/ side effects.

Notices in the patient waiting room and patient website also told patients how to access support groups and organisations. The service's computer system could not record carers however, the registered GP of a patient could upload details of carers through special patient notes.

Are services caring?

The service had information available to patients relating to support services available in the local area. Staff showed us various leaflets, for example information relating to drug and alcohol services, which were given to patients who visited.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the service population were understood and systems were in place to address identified needs in the way services were delivered.

There were systems in place to review and increase staffing levels when demand for the service was increased. For example the service used their National Quality Requirements (NQRs) to establish where and when they need to make staffing changes to respond to the needs of patients For example using the data they were able to identify that they needed to increase the number of call handlers from four to seven to meet the needs of patients. Plans were also in place for enhancing rotas over holiday periods such as Christmas and Easter.

The medical director told us they attended patient experience events. For example they had recently attended an event in one of the CCG areas and were able to promote the service and raise their profile as well as obtain feedback from patients about what they needed in an out of hours service.

Tackling inequity and promoting equality

The service had recognised the needs of different groups in the planning of its services. As an out of hours provider they catered to a broad range of patients however they had identified children under five years old and older people as the most frequent users of their service. The service was made more accessible to patients from these groups. For example appointments were more flexible and home visits were offered in more circumstances than the average.

The service had access to online and telephone translation services for patients and people who needed information in different languages. Information on the website could be translated into over 50 languages.

The service provided equality and diversity training through e-learning to all staff. We saw records to confirm all staff had received this training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events. We saw that call handlers were given additional training to deal with people with communication difficulties to ensure they fully understood their needs in the absence of them being physically present. This included meeting the needs of patients with learning disabilities.

Access to the service

There was an appointment system in place with various opening times at the nine different bases where patients could be seen. The main base at Dulwich was open Monday to Fridays from 6.30pm to 8.am the following morning and all day weekends and bank holidays. GPs gave telephone advice or invited people in for a booked appointment if required.

Comprehensive information was available to patients about how they could receive care or treatment on the services' website. There were also arrangements to ensure patients received urgent medical assistance through a triaging system with the call handlers. Call handlers had been given specific training to enable them to triage patients and prioritise calls if deemed necessary. They were given clear scripts to follow and an escalation policy where they could transfer urgent calls to the GP or send an alert through the system to ask a GP to contact a patient.

Patients were generally satisfied with the appointments system. All the people we spoke with during the inspection told us that they had been seen either before or at the appointment time they were given on the phone. Comments received from patients showed that patients in urgent need of treatment were offered an immediate appointment to attend the centre and be seen by a GP. For example, one patient we spoke with told us how they spoke with a GP and was advised to attend the centre immediately. When they arrived they did not have to wait, and they were seen immediately.

Listening and learning from concerns and complaints

The service had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance. 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. Posters were displayed in the waiting area and information was available on the website including how to provide feedback and complain. Copies of the complaints procedure was available for

Are services responsive to people's needs?

(for example, to feedback?)

download. The procedure detailed timescales for responses and how they would be involved. All staff we spoke with had a good knowledge of the complaints policy. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the service. The manager told us that if someone made a verbal complaint and did not follow it up, the complaint was still investigated in case there was a learning outcome for the service.

We looked at 37 complaints received in the last 12 months and found they had been satisfactorily handled and dealt with in a timely manner by the provider. We reviewed complaints with the medical director and saw that complaints were handled with full transparency which included fully involving the complainant and the staff member being complained about (if applicable). For example, we reviewed a complaint where a patient was not happy with a GP's assessment during a telephone consultation, which led to the consultation becoming a difficult consultation. The service fully investigated the incident including interviewing the complainant and the GP being complained about. The result of the complaint led to the service running a refresher training session for all staff on how to deal with difficult telephone consultations.

All GPs were audited every month on the number of complaints or feedback received about them. If there had been complaints or feedback, the medical director went through them with the GP to identify any lessons learnt or to promote best practice.

The service reviewed complaints annually to detect themes or trends. Quarterly and annual reports were completed which included complaints. The reports looked at themes occurring in complaints. The service explored and acted on themes that occurred. For example a theme that emerged was a concern relating to the reception area. As a result changes were made to improve the area. We saw the annual quality report for September 2013-2014. There had been a total of 18 complaints over this period and the report detailed how many were clinical, operational or both; the number that had been upheld/ not upheld; categories of complaints and the action taken or outcome from the complaint.

Are services well-led?

(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. We found details of the vision and service values were part of the service's strategy and business plan. Staff told us that clinical quality was their top priority. In order to involve staff in the processes of delivery a plan was set and tasks delegated to managers to deliver through their teams.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the service staff meeting held on 14 January 2015 and saw that staff roles and responsibilities towards achieving the service strategy were discussed.

Governance arrangements

The service had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the service. We looked at eight of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All eight policies and procedures we looked at had been reviewed at least every two years and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a medical director (who was also the lead for safeguarding and infection control), and an operations director. There was also an in-house pharmacist who was responsible for analysing data on prescribing including the management of controlled drugs. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the service with any concerns.

The service used the National Quality Reports (NQR) to measure its performance. The NQR data for this service showed it was generally performing well. We saw that NQRs were monitored daily and discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The service had arrangements for identifying, recording and managing risks. There was a risk register for the whole organisation and one of the GP board directors had lead responsibility for managing it. One of the managers showed us the risk log. We saw that the risk log was regularly discussed and reviewed at various meetings including committee and board meetings. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example they had assessed the risks associated with the current number of GPs in the 'pool' of available GPs for sessions. Staff told us that filling increasing the number of GPs available to cover sessions was the services top priority.

The service held bi-monthly committee meetings for both operations and clinical governance. There were eight board meetings per year. They also had monthly operation team and clinical governance team meetings. Senior management meetings were held fortnightly. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. They also produced annual medicines management and quality reports.

Leadership, openness and transparency

There were clear leadership structures in the organisation. There were experienced GPs on the board with management experience.

We saw from minutes that team meetings were held every three months. Staff told us that there was an open culture within the service and they had the opportunity and were happy to raise issues at team meetings. Staff told us that managers were approachable and they were constantly updated on how the service was performing. We spoke with staff at all levels within the organisation and found that everyone demonstrated an awareness of how the service was performing, indicating that leaders were open and transparent with staff.

We also noted that board away days were held quarterly and team away days approximately twice a year.

The human resources manager was responsible for human resource policies and procedures. We reviewed a number of policies (for example whistleblowing policy, induction policy, management of sickness) which were in place to support staff. Staff we spoke with knew where to find these policies if required. We were shown the staff handbook that was available to all staff, which included sections on aims and values and capability.

Are services well-led?

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

Practice seeks and acts on feedback from its patients, the public and staff

The service had gathered feedback from patients through patient questionnaires, comment cards and complaints received. Patient surveys were completed every month. Patients were asked to complete questionnaires opportunistically during their visit. The service also sent out questionnaires to approximately 5% of patients who used the service within the month (home visits, visiting site or telephone advice only). We saw that the results of patient questionnaires were analysed and shared with staff. For example results were published in the quarterly staff newsletter.

The service had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The service had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the service.

Management lead through learning and improvement

Staff told us that the service supported them to maintain their clinical professional development through training. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the service was very supportive of training and that they had staff away days and various learning and development days. service was continually monitoring activity and quality at all levels including committee level. This was to ensure the right learning and development opportunities were available to staff.

The service had completed reviews of significant events and other incidents and shared these with staff at meetings and away days to ensure the service improved outcomes for patients. For example, we saw that learning from a significant event relating to their failed contact procedure was disseminated to staff in the quarterly newsletter. It outlined the key messages for the duty doctor and a reminder of the policy relating to failed contact with a patient to minimise the incident occurring again.