HR Healthcare Limited

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Inspection report

The Office
Waters Meeting
Britannia Way
Bolton
Lancashire
BL2 2HH
Tel: 01204 559999
Website: www.treated.com

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at HR Healthcare Limited between 22 November 2016 and 1 December 2016.

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

- There were no effective systems in place for recording, reporting and learning from significant events or clinical alerts.
- Risks to patients were not appropriately assessed or managed.
- Some non-clinical staff with no formal training assessed patients' needs. Staff training was ineffective and training of clinical staff had not been assessed or monitored by the provider.
- There was no system in place that enabled staff access to patient records or information from previous consultations which made assessment and prescribing decisions reliant on the information that patients supplied.
- The service managed patients' applications for medicines in a timely way.
- The provider used an external service (Trustpilot) to measure customer satisfaction; it was rated as 9.5 out of 10.
- Information about services was available on the provider's website. There was no information about how to complain. The provider told us that they had received no complaints to date.
- We saw no evidence that the service worked proactively with other organisations and providers to develop services. There was little understanding of continuous improvement.
- There was no clear leadership structure or clinical leadership. The service did not proactively seek feedback from staff and patients.
- The provider was aware of the requirements of the duty of candour.

The areas where the provider must make improvements are:

- Ensure there is a system to ensure recording, assessing and managing significant events.
- Ensure prescribing decisions are made appropriately and in line with clinical best practice and that appropriate safety advice is provided with each prescription.
- Ensure systems are in place to deal with emergency situations.
- Ensure safeguarding procedures are in place and that staff are aware of how best to identify and deal with them.

Summary of findings

- Ensure patient identity is confirmed for each prescription and the resulting delivery of medicines is appropriate.
- Ensure that medical information displayed on HR Healthcare website(s) is clear and unambiguous.
- Ensure information about making complaints is available and that there is a system for recording, investigating and monitoring these.
- Ensure feedback from patients and staff is gathered to improve services.
- Ensure there is a clear leadership structure, with effective governance and strategies to deliver high quality care.
- Ensure policies and protocols are available to all staff.

The areas where the provider should make improvement are:

- Update the business continuity plan to include relocation and data disposal considerations.

We have suspended the registration of this provider for three months from 2 December 2016 in order to protect patients .

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff were not clear about reporting incidents, near misses and concerns. Although the service carried out investigations when there were unintended or unexpected safety incidents, there was no evidence lessons learned were communicated and so safety was not improved. Patients did not receive a written explanation or an apology when one was appropriate. We were told verbal explanations were given, but there were no records of these.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there was no system / process to confirm patients' medical history and previous prescribing decisions for prescribing medicines, and no system for managing medical safety alerts.
- There was insufficient attention given to safeguarding children and vulnerable adults. Staff did not understand how to recognise safeguarding issues.
- The company was registered with the Information Commissioner's Office.

Are services effective?

- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement.
- There was minimal engagement with other providers of health and social care.
- There was limited recognition of the benefit of an appraisal process for staff. The provider had no oversight of clinician's training and continuous professional development. Training of non-clinical staff was ineffective.
- Basic care and treatment requirements were not met. Patients did not receive appropriate "safety net" advice to support the medicines they were prescribed.
- Consent to care and treatment was not sought in line with the Mental Capacity Act 2005, there was no provider policy relating to capacity and consent.

Are services caring?

- Some information displayed on the provider's website was unclear for patients.
- Available information from patients on how well they were treated suggested that they were treated with respect and compassion.

Are services responsive to people's needs?

- The processes established by the service were not appropriate to treat patients' needs. Consultations were conducted via an on-line form and effectiveness of treatments were not available to assess.
- There was no information for patients on how to make a complaint. There was no mechanism in place for patients to make complaints.
- Systems and processes for gathering and acting on suggestions and feedback were limited.

Are services well-led?

- The service did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- There was no clear leadership structure; clinical leadership was poor and sporadic.

Summary of findings

- The service had a number of policies and procedures to govern activity; these were not readily available to on-site staff as they were in paper form. Off-site staff did not have access to policies.
- The service did not hold regular governance meetings and issues were discussed at ad hoc, non-documented meetings.
- The service had not proactively sought feedback from staff or patients.
- Staff had not received performance reviews and did not have clear training/personal development objectives.

HR Healthcare Ltd

Detailed findings

Background to this inspection

HR Healthcare Limited is a recently established organisation (registered with the Care Quality Commission in July 2016) that operates an online clinic for patients providing consultations and prescriptions and medicines. HR Healthcare employs GPs on the GMC GP register and a prescribing pharmacist to work remotely in undertaking patient consultations when they apply for medicines on-line. The service is open between 9am and 5pm on weekdays and only available to UK residents. This is not an emergency service. Subscribers to the service pay for their medicines when their on-line application has been assessed and approved. Once approved by the prescriber, medicines are dispensed, packed and posted; they are delivered by a third party courier service. The HR Healthcare is operated via a website (www.treated.com). HR Healthcare is also affiliated to a number of other on-line services which are not in the scope of their Care Quality Commission (CQC) registration.

HR Healthcare was registered with the CQC on 12 July 2016. A registered manager is in place. (A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and Associated Regulations about how the service is run).

We conducted our inspection between 22 November and 1 December 2016. We visited HR Healthcare Limited's operating site in Bolton on 22 November 2016, where we spoke to managers and staff working there. We spoke with one clinician who prescribed medicines on the day via the telephone. We spoke with another GP prescriber and the clinical lead over the telephone in the following days as and when they were available to speak with us. We looked at policies, other documentation and patient records. We concluded the inspection on the 1 December 2016.

To get to the heart of people's experiences of care, we always ask the following five questions of every service and provider:

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

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a second CQC inspector, a pharmacist specialist, and a clinical fellow.

We inspected this service as part of our comprehensive inspection programme. 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.

Are services safe?

Our findings

Safe track record and learning

There was policy in place for reporting and recording significant events, however there was no evidence this was effective.

- Staff told us they would inform the registered manager of any incidents; however staff did not have access to documents or policies to support this process. The registered manager had electronic copies of policies and the reporting form available on their laptop computer. 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 no evidence that significant events and case reviews were discussed with all staff although we were told that they would be. We were shown one significant event which had been recorded and investigated where the external courier company had mislaid a patient's medicines.
- There was no evidence that the provider 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 registered manager accepted that insufficient meetings had taken place to discuss and learning and told us that they would introduce a schedule of meetings and ensure that a variety of standing agenda items would be included.
- We reviewed the only set of minutes of meetings that were provided for a meeting 17 March 2016. We saw evidence "complaints/compliments and SEA discussions" appeared as an agenda item. There was a note of a compliment and flowers had been received by a member of staff for assisting a patient.

Overview of safety systems and processes

The service did not have clearly defined and embedded systems, processes and services in place to keep patients safe and safeguarded from abuse:

- A safeguarding policy was in place, but only in a paper form and available on the registered manager's laptop computer so staff working remotely would not have access. Clinical staff had little understanding of safeguarding procedures. When given safeguarding scenarios clinical staff failed to display appropriate understanding of what safeguarding issues might be present. There were no visible reminders or flowcharts for staff to be reminded of safeguarding procedures. The registered manager told us that some flowcharts would be produced and put on display. We were told that new systems planned for early 2017 would mean that all policies and protocols would be available to staff on a shared area of the computer systems. One non-clinical member of staff we spoke with did have an understanding of safeguarding; they told us that the system was not set up to identify patients who may be at risk. A whistleblowing policy was available; we saw the contact to the national whistleblowing telephone number was not included. The registered manager told us that this would be rectified and later sent us an updated policy which included the number.
- We asked the registered manager about how safety alerts were dealt with; they told us they relied on the GPs dealing with their own alerts. There was no system in place for recording and monitoring safety alerts, such as those provided by the Medicines and Healthcare products Regulatory Agency (MHRA). This meant that the provider had no oversight as to whether any patients were or had been affected by any medicines which were the subject of safety alerts. The clinician we spoke with could not recall any recent MHRA alerts.
- We were told by the registered manager that a patient's identity was checked before medicines were prescribed, and there was a policy that supported this. Patient's identity was checked using a system called "Equifax" which cross referenced an applicant's address with their credit card details. We were later told by a member of staff that patient's identity was only checked for antibiotic applications. Once approved by a clinician, any prescribed medicines were dispensed and packed by the provider. They were then posted and delivered by an external courier service. We were told that the courier's systems for delivery were high quality and that they checked medicines were delivered to the correct address. Identity checks were not conducted on the recipient, so there was a risk medicines were not delivered appropriately.

Are services safe?

- We reviewed four personnel files and found not all of the appropriate recruitment checks had been undertaken prior to employment. For example, three files had no proof of identity, some lacked references and all lacked a declaration of medical fitness to perform the role.
- Staff were able to work on the customer service desk or pack medicines as they were trained to perform both roles. There was a yearly planner in place to ensure not too many staff were on leave at the same time. Sickness and unexpected absences were usually covered by staff completing extra shifts or overtime. Staff told us they enjoyed working for HR Healthcare Limited.
- We looked at staff training. We were only able to look at non-clinical staff training as none of the clinical staff provided their training history or requirements to the provider. The provider told us they relied on clinicians own professional bodies to ensure their training was appropriate and up to date. Training records we looked at showed staff had received a variety of on line training. We saw that one member of staff had completed 17 training modules in one day. (safeguarding, conflict resolution, safeguarding children, privacy and dignity, health and safety, complaints, office safety, moving and handling, learning disability awareness, information governance, infection control, fire safety, equality and diversity, visual display units, dementia, customer care and counter fraud.) When we spoke to the staff member about training, they said it was hard to remember as they had done so much in one day. Training of staff was ineffective.
- The service had no systems in place which evidenced they confirmed that all clinical staff were up to date with training. The provider relied on the clinician's professional bodies, the general medical council (GMC) to ensure that clinical staff were up to date. They had no method of ensuring for themselves that this was the case. Clinical staff had access to guidelines from NICE and used this information to make decisions about patients' needs

Medicines Management

- We asked the provider what systems were in place to identify and analyse any incidents, near misses and clinical errors. We were told that there was an accident book for recording workplace incidents, such as slips and falls and that their customer feedback system gave patients the opportunity to rate the service from one to five stars. The system called "Trustpilot" is an open system provided by a third party supplier. Any information that patient put onto the system could be seen by anyone. This meant that patients were unlikely to put sensitive or personal information on the site. We were told that any issues that arose between the clinical prescribers and the supplying pharmacy were dealt with as they arose. There was no system in place for recording these types of incidents, and therefore no opportunity to review or audit them.
- We asked the clinicians how they decided which medicines to offer for sale on their website. There was no documented strategy for this and we were not assured how this list was developed. We were told that medicines were only available for delivery to patients with a UK address.
- We looked at patient consultation records and were concerned at some of the prescribing decisions. For example, one patient was prescribed four courses of seven days each of an antibiotic for urinary tract infections. This was inappropriate as the patient should have been referred for further investigation; prescribing was not in accordance with best clinical practice and national guidance. Another patient was prescribed 12 asthma reliever inhalers over a four month period. There was a risk a person may suffer a life-threatening exacerbation of asthma because they were not being appropriately reviewed in response to their high usage of reliever inhaler.
- We noted that unlicensed medicines were prescribed (for example a medicine for altitude sickness, and a cream for premature ejaculation), however patients were not informed that these medicines were unlicensed and no records were kept of the rationale for prescribing. The pharmacist, who is an independent prescriber, was not aware the service prescribed any unlicensed medicines. In addition, because the medicine is being used 'off-label', the leaflet supplied by the manufacturer did not include sufficient information about use. The provider did not provide any additional information to guide the patient about when and how to take these medicines. This posed a risk to the patients and was not in accordance with General Medical Council guidance.

Monitoring risks to patients

Are services safe?

Risks to patients were inadequately assessed and managed.

- There were few procedures in place for monitoring and managing risks to patient and staff safety. There was no health and safety policy available and no risk register. The service had up to date fire risk assessments and carried out regular fire drills. Only the provider's staff used the premises but no consideration had been given to the workplace risks or to staff working remotely. The registered manager told us that this would be addressed.

Arrangements to deal with emergencies and major incidents

The service did not have adequate arrangements in place to respond to emergencies and major incidents.

- There were no systems or protocols in place to deal with medical emergencies should one take place during an on line consultation. The clinical lead accepted the provider had no formal systems to re-contact a patient if necessary. The provider sent us a new policy after the inspection; however the policy was not effective in dealing with potential medical emergencies whilst patients were on-line.
- Staff had received annual basic life support training. A first aid kit and accident book were available.
- The service had a business continuity plan in place for major incidents such as power failure or building damage. The plan did not have information relating to where the service would re-locate to if the need arose. There was no consideration given to how the provider would deal with the personal data held on their computer systems should the company cease trading. The registered manager told us they would include this information in an updated version of the plan. The provider had service level agreements in place to ensure that data was secure and services maintained. The provider told us that data stored on computer systems was encrypted to an industry standard level but we saw no evidence of this. No telephone calls were recorded. The provider was registered with the Information Commissioner's Office (ICO).

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- The service had no overall strategy for assessing the needs of patients who were requesting medicines. Non-clinical staff with no formal training who were working on the customer service desk were sometimes responsible for checking on-line application forms, which included a questionnaire specific to the medicine applied for. These forms which were completed by patients were initially assessed for their suitability in terms of amount of medicines applied for and type. If the customer service desk operative believed the application was not appropriate or there were doubts about the patient's identity, then the application was declined. We saw no evidence of guidance to support this assessment. If the application passed the first level of scrutiny it was forwarded to a clinician for an assessment and a decision as to whether to prescribe the medicines or not. No records were kept of the rationale for the decision. If there was a need for the clinician to converse with the applicant, this could be facilitated by a "chat" function if both were on-line at the same time. This chat history was not recorded and could not therefore be reviewed. Clinicians we spoke with told us they were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The provider had no way of monitoring these guidelines were followed.
- We saw several examples of prescribing which did not stand up to scrutiny and put patients at risk. For example, a patient who was prescribed emergency hormonal contraception. This same patient had received treatment from HR Healthcare for a sexually transmitted infection one month beforehand and no counselling was recorded regarding sexually transmitted infections or long term contraception needs. There was a risk of unintended pregnancy because the questionnaire the patient completed was not properly designed to elicit the essential information to determine whether the medicine would be safe and effective for them to take.

Management, monitoring and improving outcomes for people

There was no evidence of quality improvement including effective clinical audit.

- There had been two clinical audits completed, these were prompted by advice given by CQC during the registration process. One audit we looked at relating to sexually transmitted infections contained no data. The other audit we looked at related to oral contraception and was single cycle and did not demonstrate improvement. We were told there was no overall strategy to undertake audits. We were told by the clinical lead that there was no analysis yet of the range of antibiotics prescribed and were told that they expected clinicians would use their clinical acumen when prescribing.
- There was no evidence that the service participated in benchmarking or peer review.
- No examples were provided of where audit or assessment of the service had led to any improvements for patients. There was no evidence of improved outcomes for patients.
- There was no evidence of improved health outcomes for patients.

Effective staffing

We were shown little evidence that the 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 and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period. There was a comprehensive induction check list.
- The service could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, training for on-line consultations.
- It was not clear how the learning needs of staff were identified. We asked to see staff appraisals and were told none had yet taken place because the service had only been recently established. There was no evidence of other supervision or one to one meetings having taken place. There was a staff appraisal form ready for

Are services effective?

(for example, treatment is effective)

use. The provider had no oversight of the appraisal and continuous professional development of clinicians who prescribed medicines. Non-clinical staff had access to on-line training to meet their learning needs; however the manner in which this was delivered made it ineffective

Coordinating patient care and information sharing

The information needed to deliver care and treatment was not available to relevant staff in a timely and accessible manner as staff did not have access to patient's medical notes and were reliant on the patient's summary of their medical history. Clinicians were unable to be certain what other medicines patients were taking before deciding on whether to approve a prescription application.

- As HR Healthcare was not an NHS provider there was no access to 'special notes'/summary care record which detailed information provided by the person's GP.
- The service only shared relevant prescription information with other services (GPs) if consent was given by the patient on the application form. This was an "opt in" option rather than an "opt out". We were told almost no patients opted in, though no data on this was collected.
- We saw no evidence of the provider working collaboratively with other services, other than the supplying pharmacy.

Consent to care and treatment

Staff did not have an understanding of how to seek patients' consent to care and treatment in line with legislation and guidance.

- Staff did not understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Clinicians failed to respond appropriately to scenarios we gave them relating to patients capacity to make their own decisions.
  Management and clinicians we spoke with believed that the fact a patient was able to complete and on-line form was sufficient to evidence their capacity to make decisions about their care. One member of the customer service team told us that the system was not capable of identifying people with learning disabilities.
- The provider told us they only treated adults (Patients over 18). However there was no evidence they carried out checks on whether applicants were over 18 years of age.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients when speaking to them on the telephone.

- We noted that the customer satisfaction rating on Trustpilot for the service was high (9.5 out of 10). Patients were able to rate their experience from one to five stars. We were told that if a rating was between one and three stars, then a member of the customer services team would ring the patient back to establish the reason for the low rating. No records of these calls, the reason for the rating or the result were kept. This made it difficult for the provider to learn and improve services.
- The provider did not conduct any customer feedback surveys. The registered manager told us that they would consider patient and staff surveys as a method of gathering feedback in future. We saw no evidence of cooperation with other healthcare services in relation to auditing patient experiences to improve services.
- We saw that one member of the customer service team had received thanks and flowers from a patient for the assistance they had provided.

Care planning and involvement in decisions about care and treatment

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

- Staff told us that translation services were not available for patients who did not have English as a first language. The provider's website only had information and application forms in English.
- Information on the provider's website informed patients about each medicine that was on offer and what might be the suitable dose for the condition it was intended for. Some information on the website was misleading and potentially putting patients at risk. For example one medicine used for acne is contraindicated in pregnancy, the website stated pregnancy may make acne worse on the first page, it was only if the patient made further investigations in later pages that they found information that the medicine should not be used during pregnancy (there is a risk of harm to the baby).
- The price of medicines was clearly displayed on the provider's website.
- Staff had received training in confidentiality and information governance. The provider told us that the security of patients' personal data was ensured through third party technical support and encryption services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- All patients using the service referred themselves for medicine prescriptions. None were referred from NHS services.
- Whilst the provider's website was available 24 hours a day and seven days a week, they operated from 9am to 5pm on weekdays. Patients logged onto the provider's website and gave their personal details and credit card information for payment and identification purposes. Once they had completed an on line questionnaire for their preferred medicine, the application was sent via the system to the customer service desk. An assessment was made by non-clinical staff at this stage as to the validity of the application. Once it passed or failed this stage it was sent via the system onto one of the prescribing clinicians, who made a further assessment and either declined or approved the application. The reasons for applications being declined were passed by the clinician to the customer service team who would call the applicant and feedback the reason for the decision. The reason for the decision to decline and the feedback to the customer were not always recorded, so were unavailable for scrutiny by the inspection team. Approved applications led to a prescription being issued and the medicines being dispensed by the co-located supplying pharmacy, then packed and posted out by HR Healthcare staff. A third party courier company were responsible for delivery to the patient's address.

Tackling inequity and promoting equality

- The provider treated all adults, aged 18 and over, having a UK postal address. The provider did not discriminate against any client group.
- No translation services were provided either on the website or in any correspondence with the patient. We spoke to the provider about this and they told us because the service was available to the whole of the UK population, it would be difficult to provide translation services for all minority groups living in the UK. The provider had made no assessment of the need for patients with sensory impairment and how they might potentially access their website. For example, the use of screen readers.

Access to the service

- Patients accessed the service via the website from their computer or other portable device with internet access.
- This was not an emergency service and unlikely to be a service that a patient would access in case of an emergency. There was no information of the provider's website to advise anyone with an emergency to contact the appropriate service (999, their own GP or NHS 111).
- Patients who left satisfaction comments on the Trustpilot service were generally very happy with the service. Recent comments indicated patients were pleased with the price and speed of the service.

Listening and learning from concerns and complaints

- There was no information on the provider's website about how to make a complaint. There was no direct method for patients to make a complaint. Patients could express dissatisfaction by giving a low rating on the customer satisfaction page. Low ratings prompted a call back from the customer service team; however these calls were not documented or otherwise recorded, so there was no system for recording and monitoring this feedback.
- We were shown a complaints policy, however this was only available to the registered manager's laptop or in a paper copy held in the provider's policy file. We spoke to the registered manager about these issues and they agreed that additional functionality on the website was required and a system for logging, recording and monitoring complaints was needed. We noted that soon after the inspection the provider had added information and functionality to the website relating to making complaints.

We were told that no complaints had been received by the service to date.

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

We were not shown evidence that the service had a clear vision to deliver high quality care and promote good outcomes for patients.

- The service had a statement of purpose, however staff could not tell us about its contents and objectives.
- There was no strategy or supporting business plans that reflected the vision and values.
- There was no clear organisational structure.
- We were told that no structured business or quality meetings took place and that when informal discussions did take place, these were not documented.

Governance arrangements

The service did not have an overarching governance framework to support the delivery of the strategy and good quality care:

- Service specific policies were written but not available to off-site staff, and only to on-site staff in paper form contained in the provider's policy folder or on the registered manager's laptop computer.
- There was no system of quality improvement including clinical and internal audit to monitor quality and to make improvements. The two audits we were shown were incomplete and we were told they were only completed as a result of feedback from the CQC registration team. Many recordable data items were not recorded, making audit difficult. For example, clinical decision making.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were sparse. There was no risk register and little awareness of clinical risk.

Leadership and culture

- During the inspection the provider of the service failed to demonstrate they had the experience, capacity and capability to run the service and ensure high quality care. We noted that the provider was responsive to the feedback we gave them and responded quickly to some of the issues we raised. The provider sent us some updated or new protocols which attempted to address some of the issues we raised, however they were not well thought out and only went some way to resolving the problems we identified. For example, a generic patient safety information document which failed to address the individual information required for each medicine and its relation to the patient it was prescribed for.
- Staff told us the managers were approachable and always took the time to listen to members of staff.
- 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 support training for all staff on communicating with patients about notifiable safety incidents. The management encouraged a culture of openness and honesty. However the service did not have systems in place to identify and record effectively when things went wrong with care and treatment:
- The service did not keep written records of verbal interactions with patients.
- 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, particularly by the managers.

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

- The service encouraged and valued feedback from patients via the Trust Pilot customer satisfaction system. There was no effective system for seeking feedback from the public and staff.
- The service had gathered feedback from staff through ad hoc discussion. We were shown the minutes of one meeting that had taken place in March 2016. The meeting covered training, CQC, health and safety and complaints/compliments/SEAs. We spoke to the registered manager about this, we were told they knew the meeting regime required improvement and were seeking to have more regular documented and structured meetings. We were sent a proposed meeting schedule the day after the site visit.

Are services well-led?

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

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was little evidence of a focus on continuous learning and improvement within the service. We were told that a new computer system was being developed and was due for "Go live" early in 2017. We were told that the new system would make many improvements, including policies and protocols being available to all staff via a portal on the provider's intranet.