Integrated Care 24 Limited – Head Office

Quality Report

Kingston House,
Orbital Park,
The Long Barrow,
Willesborough,
Ashford
TN24 0GP
Tel: 01233 505450
Website: www.ic24.org.uk

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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Integrated Care 24 Limited – Ashford on 12, 13 and 14 July 2016. This is a GP out of hours services which provides health care for urgent medical problems outside normal surgery hours. Overall the service is rated as good.

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

- There was an effective system for reporting and recording significant events. A wide range of events was reported. They were systematically assessed and dealt with.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Comment cards that patients completed confirmed this finding.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment and data showed most patients were seen or contacted in a timely manner. The primary care centres, from which care was delivered, were well equipped to treat patients and meet their needs.
- There was a clear leadership structure. Governance framework was strong. Staff felt supported by management. Independent challenge at board level was welcomed.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

We saw one area of outstanding practice:

- The service had a systematic approach to working with other organisations to improve care outcomes. For example they had worked with UK Sepsis Trust to develop a protocol to improve diagnosis, safety and care of patients with sepsis (blood poisoning). The protocol was made widely available.

There is one area where the provider must make improvements:

- Review the arrangements for the management and recording of controlled drugs to make them more effective.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Integrated Care 24 Limited (IC24) – Ashford is rated as requires improvement for providing safe services.

- There was an effective system for reporting and recording significant events. A wide range of events was reported. They were systematically assessed and dealt with.
- Lessons were shared to make sure action was taken to improve safety. There was evidence of outstanding collaboration with other healthcare services in implementing systems to avoid the recurrence of certain events.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- There were clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- Medicines management was generally well managed but the service must review the arrangements for managing controlled drugs.

Are services effective?

Good

IC24 Ashford is rated as good for providing effective services.

- Staff assessed needs and delivered care in line with current evidence based guidance. A range of methods were used to help ensure that clinicians kept up to date.
- Clinical audits demonstrated quality improvement and organisational performance also focussed on individual clinician's decisions.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was a consistent focus on ensuring staff had completed mandatory training. There were appraisals and personal development plans for staff. However IC24 should review the processes of staff induction to help ensure that all staff are aware of the location of emergency equipment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. The service was seeking innovative approaches to accessing

Summary of findings

relevant patient information in conjunction with other providers, through the use of a system called the Medical Interoperability Gateway (MIG) which provided wider access to records.

Are services caring?

Good

IC24 Ashford 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 for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The service was mindful of the needs of patients, and their carers, receiving end of life care and, where necessary, provided them with a direct telephone number so that they were able to access clinicians out-of- hours directly.

Are services responsive to people's needs?

Good

IC24 Ashford is rated as good for providing responsive services.

- The service engaged with the NHS England Area Team and local clinical commissioning groups to secure improvements to services where these were identified.
- Data showed that performance against the National Quality Requirements (the minimum standards for all out-of-hours GP services) helped to ensure patient needs were met in a timely way.
- Patients said they found it easy to make an appointment and data showed most patients were seen or contacted in a timely manner
- The primary care centres had good facilities and were well equipped to treat patients and meet their needs. Patients we spoke with and comment cards we received showed that patients were happy with the service provided.
- Results from the National GP Patient Survey were in line with similar services.
- There were examples of the service responding quickly to issues raised by patients outside of the complaints system.
- Information about how to complain was available and easy to understand and evidence showed that IC24 responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

IC24 Ashford is rated as good for providing well led services;

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision, it was well understood and staff were committed to it.
- There was a clear leadership structure and staff felt supported by management. This was evident at local level and board level. Staff were always able to contact senior managers and senior managers were visible across the organisation.
- Governance framework was strong and supportive of managers. There had been a significant improvement in performance.
- The service worked systematically with other organisations to improve safety and care.
- The service had recruited additional non-executive directors, with expertise in clinical governance and human resources, to provide increased independent challenge in holding the service to account.
- Staff turnover, amongst employed staff, was low. Staff told us they valued their contribution to the organisation and felt that they were “making a difference”.
- The organisation was the holder of the social enterprise gold mark, a scheme which recognised they had achieved best practice in governance, business ethics and financial transparency.
- The organisation complied with the requirements of the duty of candour and encouraged a culture of openness and honesty. Senior clinical staff personally met with patients and/or families to provide explanations when things had gone wrong.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed that this service was performing in line with local and national averages. Patients were asked three questions; whether they felt care was provided within an appropriate timescale, whether they had confidence and trust in the clinicians that they saw and to rate their overall experience.

- For Kent the results were: appropriate timescale 61%, confidence and trust 84% and for overall experience 66% of respondents rated this as good or fairly good.
- For South Essex and Great Yarmouth the aggregate results were: appropriate timescale 65%, confidence and trust 86%, and overall experience 70% of respondents rated this good or fairly good.
- These were comparable to the averages across England of: appropriate timescale 62%, confidence and trust 86%, and overall experience 67% (rated this good or fairly good).

We gathered the views of patients using the out-of-hours service. We received 46 comment cards and spoke with 11 patients. Patients found it difficult to discriminate between the NHS 111 and the out-of-hours service, in that they were sometimes not sure if telephone calls that they had received had come from one service or another. Patients said they were offered an appointment when they needed one and they told us they had also received a telephone call from the service within the timescale that had been agreed. All the patients and comments cards praised the service saying that the GPs, nurses and reception staff were professional and courteous at all times.

Areas for improvement

Action the service MUST take to improve

Review the arrangements for the management and recording of controlled drugs to make them more effective.

Outstanding practice

The service had a systematic approach to working with other organisations to improve care outcomes. For example they had worked with UK Sepsis Trust to develop a protocol to improve diagnosis, safety and care of patients with sepsis (blood poisoning). The protocol was made widely available.

Integrated Care 24 Limited – Head Office

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspection manager**.** There was a lead CQC inspector. The team included GP specialist advisers, practice manager specialist advisors, a paramedic emergency care specialist advisor, and further CQC inspectors including pharmacists and nurses.

Background to Integrated Care 24 Limited – Head Office

Integrated Care 24 Limited – Ashford is the registered location for the out-of-hours GP service provided by Integrated Care 24 Limited.

Integrated Care 24 Limited is a not-for-profit social enterprise that provides urgent medical care and advice out-of-hours for patients across much of the south east. The Ashford location provides services across Kent, a part of Essex and in Great Yarmouth. The service is contracted by the NHS clinical commissioning groups for these areas. It provides primary medical services outside of usual working hours (out-of-hours or OOH) when GP practices are closed, this includes overnight, during weekends and when practices are closed for training. The service covers a population of approximately 2.5 million patients (Kent 1.500,000, South Essex 800,000 and Great Yarmouth 230,000).

Most patients access the out-of-hours service via the NHS 111 telephone service. This service is undertaken by a different provider and calls arrive electronically at IC24 after being triaged by NHS111. Patients may be seen by a clinician, at a local primary care centre usually located adjacent to a hospital Accident and Emergency facility, or patients may receive a telephone consultation or a home visit depending on their needs. Some patients access the primary care centres by walking in or are referred from the hospital accident and emergency departments or other urgent care centres.

The health of people in Kent is generally better than the England average. Deprivation is lower than average, however about 17.6% (48,300) of children live in poverty. Life expectancy for both men and women is higher than the England average.

The health of people in Essex is varied compared with the England average. Deprivation is lower than average, however about 16.2% (41,900) of children live in poverty. Life expectancy for both men and women is higher than the England average.

The health of people in Great Yarmouth is varied compared with the England average. Deprivation is higher than average and about 24.9% (4,400) children live in poverty. Life expectancy for both men and women is lower than the England average.

The out-of-hours service, for Kent, is provided at the sites show in the table below, the inspectors visited the following sites

The out-of-hours service, for Kent, is provided at the sites show below, the inspectors visited the following sites

Ashford

Fracture Clinic,

Detailed findings

William Harvey Hospital,

TN24 0LZ.

Margate

Fracture Clinic,

QEQM,

Ramsgate Road,

CT9 4BF.

Canterbury

Kent & Canterbury Hospital,

Ethelbert Road,

CT1 3NG.

Dover

Buckland Hospital,

Coombe Valley Road,

CT17 0HD.

Folkestone

Royal Victoria Hospital,

CT19 5BN,

Maidstone.

Fracture Clinic

Maidstone Hospital,

Hermitage Lane,

ME16 9QQ.

Tonbridge

Tonbridge Cottage Hospital,

Vauxhall Lane,

TN11 0NE.

Dartford

Darent Valley Hospital,

Darenth Wood Road,

DA2 8DA.

The inspectors did not visit the following sites

Herne Bay

Queen Victoria Memorial Hospital,

King Edward Avenue,

CT6 6EB.

Deal

Victoria Hospital,

London Road,

CT14 9UA.

Cranbrook

Jockey Lane,

TN17 3JN.

New Romney

New Romney Health Centre,

Station Road.

TN28 8LQ.

Sevenoaks

Sevenoaks Hospital,

Outpatients Building,

Hospital Road,

TN13 3PG.

Gravesend

Gravesham Community Hospital,

Bath Street,

DA11 0DG.

The out-of-hours services for South Essex and Great Yarmouth are shown below, the inspectors visited the following sites

Westcliff OOH Base

Southend Hospital,

Prittlewell Chase,

Westcliff,

Essex,

SS0 0RY.

Detailed findings

Basildon OOH Base

Basildon Hospital,

Nethermayne,

Basildon,

Essex

SS16 5NL.

Thurrock OOH Base

Thurrock Community Hospital,

Long Lane,

Grays,

Essex,

RM16 2PX.

Great Yarmouth OOH Base

James Paget Hospital,

Lowestoft Road,

Great Yarmouth,

Norfolk,

NR31 6LA.

*Beccles OOH Base,

Beccles Hospital,

St Mary's Road,

Beccles,

Suffolk,

NR34 9NQ.

*Halesworth OOH Base,

Patrick Stead Hospital,

Bungay Road,

Halesworth,

Suffolk,

IP19 8HP.

In the cases of Beccles and Halesworth bases CQC inspectors visited but staff were out on calls.

The inspectors did not visit the following sites

Brentwood OOH Base

Brentwood Community Hospital,

1 Crescent Drive,

Brentwood,

Essex,

CM15 8DR.

Canvey Island OOH Base

Central Canvey PCC,

83 Long Road,

Canvey Island,

Essex,

SS8 0JA.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12, 13 and 14 July 2016. During our visit we:

- Spoke with a range of staff employed by IC24 including receptionist/drivers, clinical staff, managers and board members. We spoke with sessional GPs and clinical staff.
- Visited primary care centres, observed how patients were treated at reception areas and spoke with patients.
- Reviewed documents.

Detailed findings

- Reviewed comment cards where patients shared their views and experiences of the service.

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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

- There was a policy on what constituted a significant event and how this should be reported. The policy and the reporting forms were available on the IC24 intranet and staff we spoke with knew how to access them. The incident recording form supported the recording of notifiable incidents including complying with 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 or treatment).
- IC24 used an NHS recognised proprietary risk management system to manage the reports. Reports were escalated to board level and those that met the criteria were reported to NHS England.
- We saw evidence that when things went wrong with care or treatment, patients of families were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to help to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety. We looked in detail at an incident where IC24 had identified gaps in their response and the patient was taken to hospital with sepsis (blood poisoning). The incident was fully reported and investigated. IC24 produced guidelines showing how sepsis could be easily missed. The guidelines went to all clinicians, were posted on the intranet and included in the registrars' (trainee GPs) induction. IC24 worked with the UK Sepsis Trust to produce and disseminate a sepsis telephone triage toolkit to reduce the likelihood of a similar incident occurring. This toolkit is aimed specifically at NHS 111 and out of hours services. It is widely disseminated, particularly through the UK Sepsis trust website. The involvement of IC24, as a partner in the development, is acknowledged in the foreword.
- Another incident involved an outbreak of diarrhoea and vomiting. This resulted in a significantly increased demand on the available GPs. The on-call medical director was alerted and a mobile GP sent to deal with these calls thus reducing the impact of the high number of calls. IC24 reported the matter to NHS England and Public Health England.

Overview of safety systems and processes

There were clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a nominated lead member of staff for safeguarding. IC24 had authorised the recruitment of two new posts, one for adult safeguarding and one for child safeguarding, to work under the safeguarding lead. There were plans to use these staff to develop safeguarding work such as training and audits.
- IC24 had completed safeguarding audits, against Section 11 of the Children Act 2004. This is a self-assessment of the degree to which the organisation is meeting its obligation to safeguard and promote the welfare of children. Whilst these are self assessments they are sent to the relevant local safeguarding children board that is under a duty to ensure the arrangements are robust. The relevant boards had accepted the audits and thus provided a degree of independent scrutiny of IC24's arrangements for safeguarding children.
- New training packages had been written for child and adult safeguarding that included radicalisation under the Home Office Prevent strategy, human trafficking and female genital mutilation.
- Staff we spoke with understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level 3. Staff who had no direct contact with vulnerable people had safeguarding training if it was felt that this would enhance their role.
- There were notices at the primary care centres advising patients that chaperones were available if required. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS)

check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- The primary care centres maintained appropriate standards of cleanliness and hygiene. They were located at other NHS properties and IC24 had limited control over the environment. The centres were clean and tidy. There was an infection control clinical lead responsible for local standards and training. Annual infection control audits were undertaken and we saw that some of the issues raised were actioned and there were improvements as a result. However some issues, where they lay outside of IC24 control because, for example because they were in a hospital building, were noted in audits but were always not actioned.
- The arrangements for managing medicines, including emergency medicines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). None of the medicines used by IC24 required refrigeration. Most of the nurses had qualified as independent prescribers and could therefore prescribe medicines for specific clinical conditions. Whilst IC24 was not required by law to appoint a controlled drugs (CD) accountable officer they had appointed one and were in contact with the local CD intelligence network to promote good practice.
- In the Kent area blank prescription forms and pads were securely stored and there were systems to monitor their use. Controlled drugs were stored securely and there was a system to record when staff accessed them. All the medicines we checked, issued by IC24 were, in date.
- The inspection of the IC24 facilities in Essex found that the control of medicines management was less stringent than in the Kent area. For example prescription stationery was generally well controlled but the IC24 policy for recording the use of computer prescription pads was not always followed. We found that controlled drugs (CD) records were sometimes not properly completed, and in two primary care centres there were discrepancies between the CD cupboard contents and register entries which had not been reconciled locally. We sometimes found that CD were not being kept in the CD storage cupboards.
- We reviewed 17 personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS checks). We found two cases where the records were incomplete. These cases involved a gap in an employment record and a missing photographic proof of identity. There was no evidence of systematic failure.
- There were systems to check whether sessional GPs met requirements such as having current professional indemnity, registration with the General Medical Council, DBS checks and were on the performers list (the performers list provides a degree of reassurance that GPs and dentists are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks).

Monitoring risks to patients

There were procedures for monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available with a poster in the reception area though there were no local health and safety representatives. There were up to date fire risk assessments and regular evacuation fire drills. All electrical equipment was checked to ensure the equipment was safe to use (portable appliance testing). There was some uncertainty amongst primary care centre staff over responsibility for maintaining some equipment. Staff sometimes had their own equipment but said they would use IC24 equipment if necessary.
- There was a variety of other risk assessments to monitor aspects of safety. For example there were risk assessments for each of the primary care centres and we saw that these were current. There were procedures for checking the driving licences of driving staff, annually, to ensure they had not been removed or had had endorsements relevant to their duties. These staff were assessed annually to help ensure that they were skilled to drive at the level that might be required of them.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota for all the different staffing groups to try to ensure enough staff were on

duty. On occasion IC24 were not able to operate, or continue to operate, all of the primary care centres scheduled to be open due to staffing levels. On these occasions they planned the services that would need to be reduced so as to minimise the impact on patients. For example, in Kent, the Folkestone base would be closed because it had short shift time and it was located, geographically, in the centre of other available provision. There was a plan to close another centre if that became necessary but we were told that it had never had to be implemented.

- IC24 were aware of the problems in recruiting clinical staff. To help alleviate the problems they provided financial incentives to newly joined clinicians, who committed to filling a set number of shifts over a certain time period. IC24 had a pool of home based staff that they retained and used on in times of greater pressure.
- IC24 considered the qualifications of clinical staff, for example 15 out of 17 nursing staff were nurse prescribers, there were five pharmacists and two paramedic staff. The provider regularly checked both GP and non-GP professional registration to ensure that they were in date and that there were no restrictions placed on their practice.

Arrangements to deal with emergencies and major incidents

The provider had adequate arrangements to respond to emergencies and major incidents.

- Relevant staff received annual basic life support training and there were emergency medicines available at all of the primary care centres. Whilst most staff knew of their location we found one instance where a member of staff was not aware of the location of emergency medicines. All the emergency medicines we checked were in date and stored securely except for one instance where one medicine, adrenaline, which went out of date in March 2016.
- There were defibrillators and oxygen with adult and children's masks. First aid kits and accident books were available at the administrative centres.
- The provider had a comprehensive business continuity plan for major incidents such as power failure or building damage. There were plans to move services between primary care centres in event of being unable to access any one centre. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- There were systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Guidelines published by organisations such as NICE and Public Health England (PHE) were disseminated in different ways:.
- There were two clinical systems in use, to match the systems in use by the different clinical commissioning groups. There were prompts on one clinical record system. The other system had direct links to NICE guidance. There was a "hot topics" page on the IC24 intranet, emails and web based applications were also used. Relevant guidelines were discussed at meetings of assistant medical directors and other clinical governance groups. The systems were effective and GPs we spoke with told us of recent changes to guidelines that affected them.
- Guidelines were used when formulating policies, for example the patient group direction policy made reference to the NICE Good Practice Guidance (2013).

Management, monitoring and improving outcomes for people

There was evidence of quality improvement through clinical audit.

- There was a structured approach to auditing and improving the clinical decisions of individual GPs and other health professionals. IC24 audited approximately two percent of all clinical consultations. The audits were run every three months to help ensure that no staff were overlooked. Newly joined staff were audited as a priority. IC24 used the Royal College of GPs (RCGP) Urgent and Emergency care clinical audit toolkit, this was commissioned by the Department of Health to support Out-of-hours (OOH) providers in delivering effective clinical audit.
- The audit stressed the importance of recording key data such as temperature, blood pressure and oxygen saturation of the blood and we saw that these factors were also examined when clinician's work was examined for other reasons such as complaints.
- The audit produced a numerical score. Where a clinician achieved 80% or more they received a copy of the audit. Where the score was between 60% and 80%, the assistant medical director, for the area where the clinician worked, reviewed the audit and gave feedback on any perceived weak areas and we saw redacted examples of this. Where the score was below 60% the matter was referred to the performance management support group. This group, comprising senior clinicians and operational staff provided support and mentoring for individuals. Occasionally, where all attempts to support the individual were not successful, the individual was suspended from working for IC24 and, where appropriate, NHS England informed of the concerns.
- There were audits, including of infection prevention control, across all the primary care centres. We saw that most of the risks that were identified were actioned. However this was not so in every case, for example we saw that an audit had identified the risk of a room being unlocked when not in use but it was not clear what, if anything, had been done about this.
- Other examples of audits included prescribing audits and the use of a scorecard to help monitor and assess patient admissions to hospital. We looked at a prescribing audit of antibiotics. This showed that: prescribing levels were within NICE guidelines, that in majority of cases where a second or third line antibiotic had been prescribed there was a clinical justification and the prescribing of a named antibiotic was below the national target and had fallen year on year.
- The results of audits were shared with staff. We saw that this was done though the "hot topics" page on the IC24 intranet, though video conferencing facilities and through clinical meetings. These meetings were at locality level and also at regular medical directors day meetings. We looked at the minutes of a range of meetings and saw that audits discussed included paediatric and palliative care, calibration of equipment and quality of training.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

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

- There was an induction programme for all newly appointed staff. This enabled new staff members to become familiar with the way the service operated, its systems and ethos. Staff told us they were given sufficient time for induction and we saw evidence to corroborate this, for example we saw that new pharmacy staff performed the role as super-numerary, that is in addition to the staff already on the rota. We saw also there was no set time for this and staff with different skills and experience were permitted to become familiar within their own timeframe. Staff also received an induction, if needed when they moved between roles or were promoted to a new role.
- The service employed staff who had the appropriate skills and training to perform their required duties. This included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending courses such as annual basic life support, fire safety awareness, information governance and safeguarding. Staff told us that they received regular e-mails informing them of any outstanding mandatory training. They told us that if they consistently failed to complete the training they were taken off the shift rota until they had done so. When we spoke to administration staff we saw that there was a system to enforce this.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included one-to-one meetings, coaching, mentoring, clinical supervision and support for revalidation of GPs. All staff had received an appraisal within the last 12 months. Staff were able to develop within the organisation. We saw examples of IC24 supporting non-clinical staff, through training, to become clinicians and other examples of staff supported to become managers within the organisation.

Coordinating patient care and information sharing

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

- The service had two systems in use to match the patient records systems used in different geographical areas. One system was able to give fuller access to the patients' medical records than the other. The service was working on technical innovations, such as medical inter-operative gateways, to improve on this. Many practices used the "share my care" system so that out-of-hours GPs were informed about patients who were receiving palliative (end of life) care or who had complex needs.
- Staff we spoke with found the systems for recording information easy to use and had received training. Clinical staff undertaking home visits also had access to IT equipment so relevant information could be shared with them while working remotely. Staff felt that the equipment they used was both effective and robust. The results of consultations were shared with the patient's practice automatically, by 8 o'clock the following morning.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred. Most of the primary care centres were situated alongside Accident and Emergency (A & E) Units. Primary Care Centres referred appropriate patients to A & E and accepted referrals from them.
- Other examples included working with clinical commissioning groups to develop prescribing protocols and sharing the results of their audits with agencies where the staff concerned were employed through an agency.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. Training in the requirements of the MCA was mandatory for relevant staff. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and recorded the outcome of the assessment.

Good

Are services effective?

(for example, treatment is effective)

- Staff had access to information such as do not attempt resuscitation orders through special patient notes so that they could take it into account when providing care and treatment. However the provision of this information was dependent on GP practices putting such notes on the “share my care” system.
- Clinical staff we spoke with demonstrated a clear understanding of the importance of determining if a child was competent especially when providing contraceptive advice and treatment. We saw flow charts that helped to guide clinicians through the decision making process. Competent in this context means capable of understanding the implications of the proposed treatment, including the risks and any other options.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

Members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments. We saw that at some primary care centres, where confidentiality at the front desk was an issue, staff ensured that a television or radio was playing so that other patients could not hear what was being said. We saw that staff followed a clear desk policy and locked their computer terminals when absent from their desks.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- At several primary care centres we saw that GPs would come to the waiting area, call patients and introduce themselves before taking them to the consultation, rather than relying on the electronic patient call system.
- We saw that at many primary care centres staff had access to a quiet room where receptionists and patients could discuss matters privately.

We obtained the views of patients who used the out-of-hours service (OOH) through the CQC comment cards. We received 46 comment cards and spoke with 11 patients. Patients said that IC24 offered a good service and that staff were helpful, caring and treated them with dignity and respect. The patients sometimes did not distinguish between the NHS 111 and the out-of-hours (OOH) services, but where this was the case the comments about both were positive. Some cards did mention the waiting time but there was no theme that suggested any particular primary care centre had an individual problem.

The national GP patient survey asked patients to answer questions about their experiences of using OOH services. These questions were recently redesigned so that it was not possible to compare current and previous results. Patients were asked three questions; whether they felt care was provided within an appropriate timescale, whether they had confidence and trust in the clinicians that they saw and to rate their overall experience.

- For Kent the results were: appropriate timescale 61%, confidence and trust 84% and for overall experience 66% of respondents rated this as good or fairly good.
- For South Essex the results were: appropriate timescale 65%, confidence and trust 86%, and overall experience 70% of respondents rated this good or fairly good.
- These were comparable to the averages across England of: appropriate timescale 62%, confidence and trust 86%, and overall experience 67% rated this good or fairly good.

Care planning and involvement in decisions about care and treatment

The OOH service deals, generally, with single episodes of care, and the patients' involvement is different from providers such as GP services. Patients we spoke with said that they were involved in decision making about the care and treatment they received so far as this was applicable. This was corroborated by the patients' views from the comment cards. They said they were listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Staff we spoke with had a good understanding of consent and of the need to involve patients in decision making. A range of information was available, through the intranet and the clinical system, to staff concerning capacity and decision making, to support them. We saw for example that there was a flow chart to guide clinical staff in their decision making concerning the competence of children to make their own decisions.

Clinicians made use of Special Patient Notes (SPN) from the patients' registered GP during consultations. (SPN's are the means by which the registered GP can inform OOH services of the needs and wishes of patients. They are generally applied to patients who are likely to need OOH services such as those receiving end of life care or who have complex or multiple problems). Staff we spoke with regularly consulted these notes.

The service provided facilities to help patients be involved in decisions about their care. For example staff told us that translation services were available for patients whose English was not sufficiently fluent to manage a clinical consultation, and that these were regularly used. We

looked at the annual financial spend on translation services and this corroborated that they were used regularly. There was other support such as "text type" for patients whose hearing was impaired.

Patient and carer support to cope emotionally with care and treatment

When patients had been allocated a home visit and there was delay, a call handler made regular 'comfort calls' which provided reassurance and support for patients. IC24 had felt that their performance in this area could be improved. Under a new system the GPs' drivers would call patients, who were still waiting, from the vehicle whilst the GP was in premises seeing another patient. This had resulted in an improvement in the number of patients receiving comfort calls. in this area.

There was a bereavement policy which encouraged GPs to consider making a call to the family, dependent on factors such as their knowledge of the family, the time of day (or night) and how soon the family might be contacted by their own GP.

We saw that GPs and clinical staff from IC24 considered these factors carefully. We saw an instance, of bereavement, where, senior clinical staff visited the family to discuss all the circumstances and to offer sympathy and support.

Policy and processes prioritised palliative care calls so that those requiring a telephone call were contacted within 20 minutes and those needing a home visit were seen within an hour. There was other consideration of palliative (end of life) care patients' needs. Clinical staff could give an IC24 direct telephone number to the carers of palliative care patients. Those carers no longer had to go through the NHS 111 service so saving valuable time, stress and the repetition of the details of their very distressing circumstances. Drivers were able to stay on duty, and be paid, if an urgent visit was required rather than staff returning to the primary care centre, at the end of the shift, and handing the call over to the incoming team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

IC24 Out-of-hours (OOH) service engaged with the NHS England Area Team and the Clinical Commissioning Groups (CCG) to provide the services that met the identified needs of the local population. The local CCGs conducted needs' assessments to find where services were required and IC24 provided those services from the various primary care centres identified from the analyses.

- The National Quality Requirements (NQR) is a set of data designed to measure, in part, the timeliness of a provider's response to patient demand. There are thirteen requirements and numbers nine to twelve measure the critical areas of the timeliness of clinical assessment of the patient, whether by telephone or face to face and timeliness of face to face consultations. We look at the NQRs in detail for May 2016 and at the trends in performance for three months previously.
- The performance was generally satisfactory across these measures. For example patients categorised as "urgent" should be seen within two hours, whether at home or at a primary care centre. In this location, Ashford, this was achieved 97% of the time where the patient was at a primary care centre and 96% of the time for a home visit. Where patients are categorised as "routine" they should be seen within two hours, whether at home or at a primary care centre. This was achieved 99% of the time where the patient was at a primary care centre and 96% of the time for a home visit.
- Performance, in terms of assessing patients who attended a primary care centre, was consistently excellent with 98 - 100% of assessments being carried within the target time of 1 hour of their arrival.
- There were translation services for patients whose English was not sufficiently fluent to manage a clinical consultation, and we saw evidence that these were used regularly. There was technical support such as "talk/type" for patients whose hearing was impaired.
- All of the premises we visited used by IC24 were easily accessible to patients who used a wheelchair and for pushchairs with level access throughout, electronic doors, wide passage ways and disabled toilets available.
- Most primary care centres had a patient information folder which provided a simple explanation of what to expect on their visit. Patients had the opportunity to give written feedback on the service received.
- Despite the fact that the primary care centres were located within other providers' premises (over which IC24 had little control) the signage, directing patients to the centre was generally of a good standard and at most centres the IC24 logo was clearly visible.

Access to the service

The IC24 OOH service was available on weekday evenings and overnight from 6.30pm to 8.00am and 24 hours a day at weekends and on bank holidays. Patients accessed the out-of-hours service via NHS 111. The NHS 111 service triaged the calls and if it concluded that the most appropriate course of action was for the patient to be seen by a GP the call details were transferred electronically to IC24. IC24 then contacted the patient to make a suitable appointment based, primarily, on the NHS 111 service assessment.

Where patients came to the primary care centre without an appointment, and had not therefore been assessed by the NHS 111 service, they were seen. Staff followed the policy, which was to persuade the patient to use their mobile telephone to contact the NHS 111 service and thus access the service though the correct channel. However if this was not possible or the patient was too distressed the service accepted them and completed the necessary patient assessment themselves.

Listening and learning from concerns and complaints

There was an effective system for handling complaints and concerns which was in line with recognised NHS guidance.

- There was a system for assigning responsibility for complaints across IC24. The system allowed for complaints to be escalated if necessary to senior management and the board.
- Patient complaints were analysed and any themes identified. The most common area of complaint was delays to services. This was discussed at a weekly operations meeting, attended by executive level staff, to manage staff rotas and shortages.
- We examined the recorded complaints between 1 January 2016 and 31 May 2016. There had been 105

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaints during that period, 94 of these had been investigated and concluded. We saw that the investigations appeared open and fair in that where the investigation found that the matters complained of where justified, the complaint was upheld and the complainant informed of the findings. Opportunities for learning were used sometimes by changes to processes and on other occasions by individual learning.

- There were 11 complaints that were still open, 10 from May and 1 from April, usually because they were complex matters involving a range of different providers from whom responses were required. The oldest open complaint was three months old.
- During the period 1 January to 31 March the provider had received 293 compliments

We examined some complaints in detail;

- For example, one complaint involved the transfer of a patient to the ambulance service and the perceived delay in the ambulance response. As a result of investigating the complaint IC24 and the ambulance service developed a protocol to deal with the risk of delays and to help ensure there was an appropriate response. We saw evidence that staff had been informed about the new arrangements.
- The organisation responded flexibly to issues highlighted by complaints, for example there was a complaint about the delay in visiting a patient needing end of life care. As a result IC24 reviewed its processes. Clinical staff were allowed and encouraged to give an IC24 direct telephone number to the carers of palliative care patients so that they no longer needed to go through the NHS 111 service so saving valuable time. Drivers' instructions were changed so that they were able to stay on duty, and be paid, if an urgent visit was required, rather than staff returning to the primary care centre, at the end of the shift, and handing the call over to the incoming team.

Are services well-led?

Good

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

Our findings

Vision and strategy

IC24 Out-of-hours (OOH) services had a clear vision to deliver high quality care. There was evidence of strong collaboration and support across all staff and a common focus on improving quality of care and promoting positive outcomes for patients.

- The service has a mission statement which was displayed at the IC24 headquarters. Where it was possible primary care centres also displayed the mission statement. Staff knew and understood the values. Many staff we spoke with told us that for them the job was about “making a difference” and this phrase is central to the IC24 mission statement.
- There were regular reviews of IC24 performance and progress towards strategic goals or strategic change. For example there was major change to service provision planned for the near future. We saw that this was discussed at board level with consideration of "go" or "no go" dates which mandated whether the change could go ahead. The board considered external influences such as how the actions of other providers or NHS agencies might impact on those dates. The proposed change would impact on staff and the board ensured that staff were kept informed and reassured about how the change was being managed.
- The organisation had been awarded the Social Enterprise Gold Mark in 2014. The award recognised the provider's best practice in three key areas namely; governance, business ethics and financial transparency. Staff were proud of their achievement and many wore the award’s lapel badge in celebration of it.

Governance arrangements

There was an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff we spoke with understood who their managers were and how to contact them. They said the managers always responded when contacted.
- There were IC24 policies and processes available through the organisation’s intranet. Staff said that the system was easy to use and the policies were easy to understand. We asked a number of staff to demonstrate their familiarity with the system and all were able to do so. Staff were confident that if they did not know about a policy they would be able to find out.

The board and the localities management had a comprehensive understanding of current performance.

- Rotas were arranged up to three months in advance. Staff were able to identify any shortcomings and address them if possible.
- IC24 was in the process of conducting detailed studies of the workload and staffing at each of its locations. These were discussed at board level, we sat in on a board meeting and saw that non-executive directors robustly challenged the conclusions and some of the assumptions on which they were based.
- There was regular video conferencing between local management and board members which focussed on performance locally. Staff told us they felt supported, rather than exposed, by this process which concentrated on seeking solutions to issues.

A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

- We saw that individual GP decisions were subject to scrutiny through audit. Staff told us that they received the results of their audits, for example they could tell us their score on their last audit. They said that they could act on the information to improve their clinical performance.
- There had been audits of antibiotic prescribing and a scorecard system had been introduced to assess and manage admissions to hospital. However audit was used advisedly and not as an absolute measure. For example some clinical commissioning groups wished to introduce a target for the percentage of patients who were admitted to hospital so as to reduce the pressures caused by hospital admissions. IC24 strongly resisted this on the grounds that such a target might have an adverse impact on individuals’ clinical judgement.

Are services well-led?

Good

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

There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. There was red, amber and green (RAG) risk assessment system and identified risks were discussed each month at board level.

Leadership and culture

The provider ensured 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 providing training for all staff on communicating with patients about notifiable safety incidents. The organisation was not satisfied that it had done all it could in this regard and had plans for further training in duty of candour and managing the coroner's inquest process.
- There was a culture of openness and honesty. When things went wrong with care and treatment IC24 gave people who were affected reasonable support, truthful information and a verbal and written apology. For example we saw that senior staff had visited the family of a patient and provided explanations and support for them. There were written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management. There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns. Staff surveys provided a positive view of the relationship between IC24 and their staff

- IC24 had recruited additional non-executive members to the board to provide challenge, within their areas of expertise. We saw that non-executives spoke out, and were listened to, for example challenging the basic assumptions upon which a particular study, examining staff allocation against demand was based.
- There were regular team meetings. Staff at all levels were encouraged to attend. For example staff who worked nights were paid to attend local meetings which were held outside their usual working hours. Staff gave examples when they had attended meetings and raised issues of concern to them and the issues had either been resolved or they were given an explanation as to why an issue could not be resolved.
- Staff said they felt respected, valued and supported, Staff at primary care centres, some of them quite remote and all operating unsocial hours, told us, consistently, that they felt well supported by managers and saw senior managers regularly. Some staff named executive level managers that they had approached with issues that had then been dealt with. Staff were able to contact a duty manager at any time. For example the duty manager could provide the telephone number of the on call social services for any particular geographical area.
- There was support for staff, who had been involved in traumatic situations such as a child death, in the form of access to counselling services and we told that staff had used these but there was no further documentation available.
- Staff said they felt respected, valued and supported, by the provider. For example IC24 sponsored a Christmas party for each local area with staff paying a nominal fee towards it, Staff who worked on Christmas day received a take away meal at their location and staff received Easter eggs. Staff told us that, small though these things were, they did make staff feel valued.
- Staff turnover, amongst employed staff, was low, for example 17% of the workforce had more than 10 years' service and 37% had over 5 years' service.

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

Feedback was encouraged from patients, the public and staff. Staff told us that patient engagement was difficult as the service provided single episodes of care. However they had tried innovative approaches such as;

- Inviting patients to the centres to meet staff.
- Producing promotional films to shown some of the difficulties and satisfactions that staff experienced.
- IC 24 used patient experience questionnaires but was moving from a paper based system to an electronic system because this was quicker to complete and

Are services well-led?

Good

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

might, therefore, encourage a greater uptake. Survey machines were located, or planned to be located at the primary care centres. Return on the paper based questionnaires was between 1% and 3%.

We saw several instances of responding to patient needs.

- For example a GP had called on a patient and receiving no reply had left. Subsequently it was found that the patient had mobility issues and could not, open the door quickly. There had been no complaint but the patient had provided feedback. The patient assessment was altered to include questions about mobility so that there was an opportunity to tell the staff of their situation and to record information such as key codes so that staff could gain to access the property.
- There was patient feedback identifying the need to have sanitary towels available for use following any internal examination. The suggestion was immediately adopted and the necessary equipment provided to all the primary care centres.

The provider had gathered feedback from staff through meetings, formal appraisals and one to ones. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They felt involved and engaged to improve how the service was run.

Continuous improvement

There was a focus on continuous learning and improvement.

- There was a range of clinical learning opportunities, for example there had been webinars (a virtual forum) and workshops on mental health issues and sepsis. These were attended by GPs from across all of the primary care centres run by the organisation.
- IC24 provided development opportunities for staff with identified training needs, for example GPs who had asked to attend the telephone triage course had been supported to do so. IC24 participated in a training scheme with the local Deanery (a Deanery is a regional organisation responsible for postgraduate medical training) to train OOH GPs. It also supported GPs, through training opportunities to become educational supervisors. IC24 provided training opportunities for GP registrars (trainee GPs) and these staff were supported by GPs who were qualified GP educational trainers.
- IC24 was developing a series of staff annual awards aligned to their values, awards were planned for, amongst other areas respect, integrity, excellence and making a difference.
- We spoke with staff, clinical and non-clinical, who had been supported to develop as managers and to attend training for managers such as complaints' management training. Many of the staff in critical management positions had been with IC24, and its predecessor organisations, for many years. They felt that their worth had been recognised. They said that they had been mentored, coached and trained through the organisation to manage the responsibility they now held.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. 12 (2)(g) the proper and safe management of medicines; In that the provider failed to store controlled drugs in accordance with regulations and failed to maintain registers of the use of controlled drugs in a way that ensured patient safety.