Integrated Care 24 Limited

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Integrated Care 24 Limited (IC24) provide an urgent care centre service at Queen Mary's Hospital, Sidcup. The service is an 'out-of-hours' primary medical service operating between 9.45pm and 8.00am, seven days a week including bank holidays. Sessional GPs and agency nurses are employed by IC24 to run this service. At all other times the centre is operated by Oxleas NHS Foundation NHS trust using NHS staff. The service is commissioned by Bexley Clinical Commissioning Group (CCG). There are other out of hours providers commissioned by Bexley CCG for use between 18.30 and 08.00. These include an NHS 111 service and accident and emergency departments. However, this report relates only to the out-of-hours service provided by IC24 at Queen Marys Hospital between the hours of 9.45pm and 8am.

During our site visit we spoke with four patients and five relatives who were using the out-of-hours service. We spoke with three members of the clinical and administrative staff. We also spoke with the Head of Operations, Operations Manager, head of medicines management and director of clinical services during a visit to the organisations head office in Ashford. The operations manager accompanied us on the site visit.

Patients were confident in the care they received. One patient said "everybody knows about this hospital. It's got quite a good reputation."

IC24 had good leadership and internal management structures. Communication within the organisation was effective especially regarding the communication of changes, updates and safety information.

Learning from feedback, incidents, accidents and complaints was handled effectively at the service. We found the service had effective clinical governance structure in place. This structure was instrumental in identifying where care had not been effective, understanding why this had happened, learning lessons from the issues and putting systems in place to reduce and prevent any recurrence.

Patients were cared for in a clean and hygienic environment.

Medicines were supplied readily. However, there was no robust audit trail for the supply of medicines given to people at the centre and there were not effective systems in place for the obtaining using, safekeeping, storing and supply of medicines.

The organisation had clear policies relating to recruitment and retention of staff, which included recruitment of sessional doctors, confirmation of eligibility to work in the UK and induction. However, we were not satisfied that systems were in place to ensure that evidence of these checks was held for some existing staff. We checked the recruitment file of one doctor and saw no evidence in the file that a criminal records check (Disclosure and Barring Service check) had been performed.

The recruitment of agency nurses was also based on assumptions that recruitment checks had been performed by the agency. There was no evidence the clinical competencies of agency nurses had been assessed. The induction process for agency nurses was poor resulting in gaps of essential knowledge.

We found the service was effective in meeting the wide ranging needs of patients that presented and the varying levels of demand that were placed on it. Care received by patients was audited and information shared with patient's usual GP where the patient volunteered this information. There was no real evidence to show continuity of care between different providers as the service appeared to work in isolation.

Patients received a caring service. They told us that they were involved in discussions about the health care they received and gave consent before it was provided. We observed patients being treated with sensitivity and respect by staff. However, we found privacy was not always protected.

The service was responsive to the needs of patients. There were opportunities for patients to provide feedback about the care they had received. Staff had access to equipment, guidance and where possible information about the patient to support clinical decisions and effectively respond to those in urgent need.

Summary of findings

However, some emergency equipment and lack of training in its use meant that staff may not always be able to operate the equipment in any medical emergency that may arise.

Access to the premises was appropriate for patients with mobility difficulties.

We found appropriate information was provided for staff in the format of policies, procedures, intranet, staff handbook and email communication. Regular staff described the service as well-led and said they felt supported. Information was routinely shared with staff via email, telephone and the intranet. However, we found that there were limited opportunities for agency staff to formally discuss issues relating to their work. Performance was monitored through audits using set criteria with common themes but it was not always clear that this monitored clinical decision making.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The provider had effective systems in place to protect patients from avoidable harm and abuse. Staff were aware of policies and procedures in place for reporting serious events, accidents, errors, complaints and for safeguarding patients at risk of harm. Incidents were investigated and acted upon and any learning shared with staff to mitigate any future risk.

There were not effective systems in place for the obtaining using, safekeeping, storing and supply of medicines and further record keeping is needed to strengthen the audit of medicines issued and improve prescription management.

The management of recruitment was not consistently managed. While permanent administrative staff were recruited to high standard, clinical, sessional and agency staff recruitment relied on partner agencies or staff themselves to produce evidence that staff were suitable to work with vulnerable adults and children. The induction processes for agency staff was poor resulting in staff not being aware for example of where emergency equipment was stored.

Infection prevention and control was effective and staff were aware of their roles and responsibilities. However, reminding staff about effective hand washing would reduce the risk of spreading infection.

Are services effective?

The provider managed patient demand for the service effectively. Staff had limited information about patients that presented to the service but used the information they had effectively to prioritise and ensure patients received appropriate care. Reception staff were trained to be able to recognise when patients needed urgent care and were supported by clinical staff to ensure that urgent need was met. Feedback from patients about the service was very positive.

There were systems in place to monitor the effectiveness of treatment provided and the provider acted upon the findings.

Are services caring?

Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. Patients were able to consent to their care and treatment and were treated with respect and sensitively.

Some general information for patients about the service was inaccurate and treatment rooms did not always provide the privacy patients may need.

Are services responsive to people's needs?

The service had good arrangements in place to ensure that it could meet the demand and needs of the patients that presented at the service with minimal delay. Staff told us that they had access to equipment needed to attend to patient's needs. Staff had access to information needed about local services available should a patient require specialist or secondary care.

Staff were aware of arrangements in place for responding to medical emergencies that may arise. However not all staff knew where the emergency equipment was kept or had been provided with training on its use.

There were opportunities for patients to express their views about the service they received.

The service was accessible for patients with mobility difficulties and there were facilities for patient translation services for patients whose first language was not English.

Summary of findings

Are services well-led?

Staff who worked within the service described a supportive and open work environment and patients gave positive reviews of the service received. There were arrangements in place to learn from incidents and complaints which were shared with staff. Audits, surveys and incident reporting processes were undertaken. We saw records to demonstrate findings were always acted upon.

Regular staff received support and feedback as a way to discuss their performance and issues relating to their role. However, this was not always available for agency staff to formally raise any issues or concerns they might have about their work.

Summary of findings

What people who use the out-of-hours service say

We spoke to five patients who had used the out–of-hours service during our inspection. We also spoke with the parents of a child who had used the service. All comments received were positive. Comments included that the service was **"**convenient and in comparison to other options better". Parents said they were "Relieved" following the treatment of their child and another patient said they "tried not to phone 111 as they knew they could receive 24 hour care at the centre.

Patients told us that they were treated with dignity and respect and that their health options were discussed with them in a way they could understand. Feedback received from patients supported the comments that had been recorded by patients on the NHS choices website.

Areas for improvement

Action the out-of-hours service MUST take to improve

The provider did not have robust processes in place to evidence or give assurance that appropriate pre-employment checks or assurances that these checks had been performed on temporary and sessional staff. These included Nursing and Midwifery Council register checks, clinical competency check and criminal records/ disclosure and barring checks to safeguard patients from un-vetted staff.

The provider did not provide agency nurses with a robust induction process to include information on dealing with emergencies including locating where the emergency drugs and equipment was located and training in equipment use.

The provider did not have effective systems in place for the obtaining using, safekeeping, storing and supply of medicines. The monitoring, audit and record keeping of medicines was inadequate. There were no assurances that patients are given the relevant safety information and that medicines are safely managed.

The provider did not have effective processes in place to ensure that patients and staff are protected from the spread of infection. The staff were not using effective hand hygiene.

Action the out-of-hours service COULD take to improve

- Improve the information folder for patients to ensure it contains relevant information for patients.
- Include agency staff on the regular three monthly clinical meetings to increase communication and effectiveness.
- Introduce systems so CQC would be informed as a contact organisation as part of the the emergency contingency plan.
- Ensure systems are in place to monitor that all staff have received basic life support training.
- Introduce systems to make sure all staff are aware of their responsibilities with the Mental Capacity Act 2005.
- Consider ways of improving working with other health and social care providers.
- Improve ways of providing privacy for patients in treatment rooms.

Urgent Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP and practice manager and expert by experience. The team also included a CQC evaluation Advisor.

Background to Urgent Care Centre Queen Mary's Hospital, Sidcup

Integrated Care 24 Limited (IC24) provide an urgent care centre service at Queen Mary's Hospital, Sidcup. The service is an 'out-of-hours' primary medical service operating between 9.45pm and 8.00am, seven days a week including bank holidays. Sessional GPs and agency nurses are employed by IC24 to run this service. At all other times the centre is operated by Oxleas NHS Foundation NHS trust using NHS staff. The service is commissioned by Bexley Clinical Commissioning Group (CCG). There are other out of hours providers commissioned by Bexley CCG for use between 18.30 and 08.00. These include an NHS 111 service and accident and emergency departments. However, this report relates only to the out-of-hours service provided by IC24 at Queen Marys Hospital between the hours of 9.45pm and 8am.

Any person entitled to NHS care in the UK can access the service in person.

The service provides care for patients who have minor wounds, illnesses and injuries. There were no x-ray facilities overnight.

The number of people seen during the out-of-hours period varies between 4 and 26 people per night. The provider does not carry out home visits as part of the out-of-hours service.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' 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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Detailed findings

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share what they knew about the service. We carried out an announced visit to the head office on the 12 March 2014 and to the urgent care centre on the evening of 12 March 2014 finishing at 02.00 on 13 March 2014. During our visit to the urgent care centre we spoke with four patients and five relatives who were using the out-of-hours service. We observed how people were being cared for and reviewed personal care or treatment records of patients. During our inspection of the head office we spoke with the head of operations, operations manager, head of medicines management and director of clinical services. The operations manager also attended the inspection of the urgent care centre.

Are services safe?

Summary of findings

The provider had effective systems in place to protect patients from avoidable harm and abuse. Staff were aware of policies and procedures in place for reporting serious events, accidents, errors, complaints and for safeguarding patients at risk of harm. Incidents were investigated and acted upon and any learning shared with staff to mitigate any future risk.

Medicines were supplied readily. However, there was no robust audit trail for the supply of medicines given to people at the centre and there were not effective systems in place for the obtaining using, safekeeping, storing and supply of medicines.

The management of recruitment was not consistently managed. Permanent administrative staff were recruited to high standard. However, clinical, sessional and agency staff recruitment relied on partner agencies or staff themselves to produce evidence that staff were suitable to work with vulnerable adults and children. The induction processes for agency staff was poor resulting in staff not being aware for example of where emergency equipment was stored.

Infection prevention and control was effective and staff were aware of their roles and responsibilities. However, reminding staff about effective hand washing would reduce the risk of spreading infection.

Our findings

People's views

We spoke with four patients that were using the out-of-hours service on the day of our inspection and five relatives, including parents of a child who was being treated. All the comments we received were positive and did not raise any concerns about patient safety.

The service provided

The urgent care centre operated between 21.45 and 08.00. The doctor and a receptionist were present throughout this time. The nurse worked during the peak times until 02.00.

Patients were confident in the care they received. One patient said "everybody knows about this hospital. It's got quite a good reputation."

We saw that the receptionist made the initial decisions about triage to the appropriate clinician. The receptionist was able to fast track children and those with respiratory difficulty. The doctor explained that as the service was small and usually not rushed there were ample opportunities for him, as the GP to discuss patients waiting to be seen with both the receptionist and the nurses on duty. We spoke with the nurse who said she usually saw patients according to her competencies. We observed that the nurse was able to refer the patient to the doctor or ask for a second opinion.

We spoke with the staff about timescales. They both informed us that because of the nature of the service they were not usually busy. The provider representative confirmed that monthly figures of attendees and timescales were routinely reported to the main office in Ashford but they were not aware as to how these were used.

Equipment and the building

The design, layout and maintenance of the department where the urgent care centre operated from was not mainatined by IC24. Staff said the agreement worked well. Staff explained equipment such as blood pressure machines, resuscitation equipment, medicine refrigerators and oxygen was supplied and maintained by the NHS trust but used by IC24 staff.

There was an information folder for patients to use. This contained details about the service. However, the information was not relevant for the urgent care centre and could be misleading for patients. The folder, however, contained information on how patients could make a complaint about the service they had received.

Medicines Management

There were not effective systems in place for the obtaining using, safekeeping, storing and supply of medicines and further record keeping is needed to strengthen the audit of medicines issued and improve prescription management.

We found there was some concern and lack of clear processes regarding the use of refrigerated medicines belonging to the NHS trust. We were informed by staff at the head office that no refrigerated medicines were used at the urgent care centre. However, the nurse on duty explained that some refrigerated medicines, belonging to the NHS trust were used and fridge temperatures for the safe storage of these medicines were managed by the NHS

staff. The provider representative was not aware of this agreement. This may mean that medicines are being given that have not been authorised by either IC24 or the NHS trust.

Other medicines supplied by IC24 were stored on site and kept securely in a designated IC24 medicine cupboard. This was a locked cupboard in a side area away from patient accessible areas.

When IC24 were not operating their service, the keys for medicine cupboards and prescription pads were securely stored.

A separate box for injectable medicines was stored in the IC24 cupboard. This contained an additional box for emergency (anaphylaxis) drugs and recommended dosages along with a selection of needles and syringes. All were within date.

We spoke with the nurse and it was apparent they did not know where the emergency medicines or equipment were kept or how to access them. This was bought to the attention of the provider representative attending the inspection.

All of the medicines we saw were in date. Storage areas were clean and well ordered.

There were no clear process for the use of prescriptions. When issuing medicines to two patients we noted that a FP10 (green prescription form) was not completed. The patient was asked if they normally paid for such prescriptions and replied that they did not. This was accepted without asking for the exception category and no record of this information was kept on the patient record.

We saw that effective stock control systems were in place for medicines coming from the central stores to the urgent care centre. All stocks were reviewed by a member of the pharmacy team. They visited weekly from the main office in Ashford to restock the used items up to the agreed stock levels. A similar list was kept centrally. However, the dispensing of medicines and recording processes for medicines leaving the cupboard were less robust. For example we observed that stock numbers were not monitored as items were removed for dispensing.

We saw one patient was offered medicine. This was collected by the nurse. No stock record was completed and this was then recorded as an entry on the patient's clinical record.

This meant there was no audit trail for the usage of medicines unless each patient record was checked. We saw packs of medicines which had been split. For example we saw two boxes of diazepam (sedative) which had been split and one box of cocodamol (pain relief). The nurse on duty and the provider representative both told us this was "not common practice." However, we saw a poster in the cupboard that read "Please mark with a cross and write the number of tablets left in the box and place back on the shelf." There was confusion relating to the practice of this and an increased risk that patients would not be issued with information relating to their medicines, including side effects. During our observations we saw that information was shared with the patient concerning side effects. The member of staff used the medicine pack patient information leaflet to describe the commonest side effects and added this to the clinical record as free text.

However, for another patient this was not done until the patient specifically asked for the information. This arrangement of split packs may increase the risks associated with unsafe storage.

We were told by both staff on duty that communication regarding of safety alerts/NICE guidance relating to medicines was good and done through email updates. The doctor we spoke with was aware of the medicines management policy and accessed this during our inspection using the organisations intranet.

Staffing arrangements

The organisation had clear policies relating to recruitment and clear processes for recruitment, recruitment of sessional doctors, confirmation of eligibility to work in the UK and induction.

We visited the head office for the organisation and looked at four staff files. The two receptionist files had been managed by the Human Resources department for the organisation. They were clear, well organised and contained all relevant selection and recruitment records.

We looked at the staff files for two sessional doctors who worked at the urgent care centre. These were managed by the operations staff at IC24. Both files had key documents missing including photograph, written references and details of an employment history. Neither file contained evidence that the doctors had attended recent first aid or basic life support training. One file did not contain evidence that a criminal records or disclosure and barring check had

been performed. Both members of staff had been employed by predecessor organisations but this demonstrated a lack of checking system or audit to ensure relevant training and employment information was present.

We asked to look at a more recently recruited doctor who did not work at the urgent care centre. This showed that the recruitment process followed by IC24 was more robust. However, files were disorganised and difficult to audit.

We spoke with operational staff about the use of agency nursing staff. We were informed that due to the nature of the urgent care centre contact it had been difficult to recruit nurses to the post. This had resulted in IC24 using agency nursing staff.

During the inspection we did not have evidence that the nurses had gone through a thorough recruitment and mandatory training process. We did not see details of NMC (Nursing and Midwifery Council) checks, criminal records bureau checks (now called Disclosure and Baring Service-DBS). We were provided with a confirmation email from the agency, a recruitment policy and a copy of the terms of business agreement for the organisation and agency. However, this was only after we had requested the information. This showed that IC24 are not proactive in ensuring appropriate employment checks had been performed on staff.

We spoke with staff at the urgent care centre. It was apparent that permanent staff had received a thorough induction from the organisation. However, the agency staff had not received an appropriate induction. For example, the agency nurse at the inspection had been working at the urgent care centre once a week since September 2013. They told us that on their first shift the induction consisted of the manger setting them up with a password and showing where the intranet was for polices etc.

We spoke with the nurse and it was apparent they did not know where emergency medication or equipment was kept or how to access it. This was bought to the attention of the provider representative attending the inspection.

We were informed that clinical competencies of the agency nurse had not been assessed. The nurse told us they “saw patients within their competencies.” However, we had concerns with some clinical decisions and actions. These were fed back to the provider representative who was present at the inspection.

The organisation also provides staff with a handbook which can be located on the intranet. This contained policies, procedures and details of how to contact the management team. The agency nurse said she had located this.

The nurse and doctor told us they had their consultations audited shortly after employment and then every six months. This audit looked at how staff had recorded the reason for visit, history, diagnosis, management, prescribing, use of IT system and safety netting. These audits are then followed up at a Performance Management Group and any action points then fed back to staff where additional support was offered. Common themes were fed back to all staff using a “bullet point” document. We saw that issues had included not recording or giving full safety netting advice. This means advice for patients of what to do if symptoms worsen.

We spoke with the doctor about training. He told us that he felt the leadership 'fully supported' his development needs. The doctor told us he had completed on line safeguarding training but was not able to access this during the interview. The agency nurse had been asked to bring details of their continuous professional development for this inspection. This was not detailed and contained two certificates.

Infection control

We looked at the urgent care department.. The cleaning of the service is managed by the NHS Trust. All areas were clean and tidy. Clinical waste bins and sharps boxes were not overflowing and personal protective equipment was available for staff use. During our observations we did not see this member of staff wash their hands between patients.

We saw there were detailed policies and procedures on the staff intranet relating to infection control. Both staff knew how to access these.

Safeguarding procedures

We spoke with staff about Safeguarding vulnerable adults and children. They had received recent safeguarding training and were aware of the process to follow if they suspected abuse. Staff knew where to find the policies and procedures for safeguarding. We saw the policies for safeguarding and noted that they referred staff to external safeguarding agencies which is good practice.

During our office inspection we saw evidence in staff files of safeguarding adult and child training.

Are services safe?

Learning from events

The provider had good policies in place to protect patients from avoidable harm and abuse. There were clear processes, policies and guidance for staff to use when dealing with accidents, incidents, complaints and medicine errors by the service.

There were clear processes in place to monitor any accidents, complaints or serious untoward incidents. For example monthly clinical governance meetings were held, any trends or issues were discussed and escalated to this meeting which was chaired by the medical director. We were shown evidence to demonstrate IC24 were responsive to feedback from other healthcare professionals and patients.

Staff were included in the analysis or resulting actions for these events. The doctor informed us there were regular three monthly meetings that included one of the medical directors from IC24, staff and clinicians who worked at the centre. However, agency staff who regularly work at the centre were not included in this meeting.

We were informed by both members of staff on duty that any patient safety alerts were communicated well by the organisation. The doctor told us he received regular emails from the head office and found the directors very approachable.

Dealing with emergencies

We spoke with staff at the head office of the organisation about emergency procedures. We were shown the contingency plan which was detailed and described action to take in the event of fire, loss of systems and major incidents. We were informed that regular meetings take place to discuss scenarios.

CQC were not listed as an organisation to inform should there be a loss of service provided.

We were also provided with examples of working with other stakeholders to improve services. An example included liaising with a local ambulance trust to improve understanding of the scope of practice of the urgent care centre following inappropriate referrals. The doctor on duty said the ambulance used to “deliver patients to the entrance for clinical assessment. These had not always been appropriate for the level of service provided by IC24 so this no longer occurred.”

Staff working at the urgent care centre told us they had received basic life support training. However, neither of the doctor staff files we inspected at IC24 head office contained evidence of basic life support training. The provider told us that they had asked the doctors to produce evidence but this had not been provided.

The doctor working at the urgent care centre was aware of where the emergency medication was stored and told us of an incident where this had been successfully used in the past. However, the nurse on duty was not aware of this.

Staff at the urgent care centre told us they used the NHS trust emergency equipment and that this was maintained by NHS staff. We looked at the equipment and saw it had been regularly maintained. However, the defibrillators were not of the automatic type and would possibly require a more detailed training programme than the basic life support required by staff in primary care for the clinicians to be able to use.

Staff working at the urgent care centre told us they felt safe working in the department. Staff said it was a small department so shouts of help would be heard. There was a security guard presence throughout the hospital and hand held radios for staff to use in an emergency.

Are services effective?

(for example, treatment is effective)

Summary of findings

The provider managed patient demand for the service effectively. Staff had limited information about patients that presented to the service but used this information they had effectively to prioritise and ensure patients received appropriate care. Reception staff were trained to be able to recognise when patients needed urgent care and were supported by clinical staff to ensure that urgent need was met. Feedback from patients about the service was very positive.

There were systems in place to monitor the effectiveness of treatment provided and the provider acted upon the findings.

Our findings

Outcomes for patients

Patients and relatives we spoke with told us that they were satisfied with the service they had received. We saw that there were 36 comments from patients posted on the NHS choices website about the urgent care centre and that the majority of these were very positive.

Patients we spoke with all told us they had come to the urgent care centre because they got seen quicker, knew it was a walk in centre and that the service was the best option in their circumstances.

All patients said they felt in control of their treatment and had consented to their treatment.

Monitoring guidance, standards and best practice

We asked the doctor about systems for monitoring standards and best practice. The doctor explained he had recently completed an audit of patients with urine infections and antibiotic use over a 3 month period. The doctor identified that the guidance for recommended antibiotics had been followed.

We saw that patients with mental health issues were managed and treated well. The doctor explained that there was a psychiatric nurse service on site where a nurse could be contacted 24 hours a day for advice. In addition another local hospital had psychiatric services that could be contacted for referral.

The nurse on duty explained that she would refer patients to the doctor who did not have capacity to make decisions. The doctor was aware of making appropriate decisions. However, the nurse and doctor had not received any training in the Mental Capacity Act 2005. This may mean that decisions making processes may not follow best practice or legal guidance.

Patients identified for end of life care were not usually seen by the service and there were no special patient notes. This meant that end of life plans from patients had not been identified as an issue at the urgent care centre.

Monitoring and improving

On arrival to the department patient details were entered by the receptionist using the bespoke computer software provided by IC24. This was reliant on the patient volunteering the name of their GP and other clinical details.

The computer system provided a template for recording consultations. This consisted of the minimum of fields but covered the basics of an adequate record. The record included separate fields for symptoms, objective signs, diagnosis and treatment including medication. There were also separate fields for medication history and past medical history. Most of the clinical details were entered as free text with some pull down lists for common diagnoses.

The provider may wish to note that this means monitoring of clinical decisions and care relies on manual examination of the patient records.

Multi-disciplinary working

The urgent Care Centre operated between 21.45 and 08.00. During this time patients were either seen by the doctor or nurse. Patient details were entered by the receptionist using the bespoke software provided by IC24. This was reliant on the patient volunteering their clinical details and name of their GP. The service was not able to confirm these details prior to forwarding information back to the GP practice (if available) the following morning.

The doctor informed us that if he needed to contact other providers or healthcare professionals this was usually done by telephone.

We saw that there were no local care pathways so coordinating care with other providers was not usually done. We were also informed that patients identified for end of life care were not usually seen by the service.

Are services effective?

(for example, treatment is effective)

There were no examples of working with other health or social care providers.

Are services caring?

Summary of findings

Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. Patients were able to consent to their care and treatment and were treated with respect and sensitively.

Some general information for patients about the service was inaccurate.

Our findings

Patient involvement

We spoke with five patients and five relatives. They were all very happy with the care and treatment they were provided with.

Patients felt involved and informed about the care and treatment they received. Only one patient expressed concerns with the ability of a member of staff. These concerns were fed back to the provider representative at the time of our inspection.

Respect and trust

We saw that patients gave consent for examination and this was recorded in the patient notes. Some patients gave implied consent. For example holding out an arm for a blood pressure to be taken.

All interactions were respectful and professional.

Patient understanding

Patients told us they understood the treatment and options given to them. One patient said that the communication was good and were told everything they wanted to know.

We did not see any patient information leaflets in use for common illnesses but patients said this was not a problem as the doctor had explained what they needed to know. However, the provider may wish to note that one patient had to ask the nurse about the medication they had been given.

Patients did not fully understand the different services on offer in their area. However, they all knew about the urgent care centre and knew there was a doctor availiable 24 hours a day. Other patients told us they were aware of the service because they had lived in the area for years.

Safety, comfort dignity and empathy

There was a comfortable waiting area at the urgent care centre and drinks machine serving cold water.

Reception staff said if they noted someone in excessive pain they would speak with the doctor.

Patients knew of the chaperone service. One patient said they knew and would have asked for it if they wanted.

Staff were aware that some aspects of the building were not always ideal and did not promote dignity and privacy for patients. For example, the sound proofing between treatment rooms was ineffective meaning confidential conversations could be heard from the other room. During the inspection we heard confidential conversations being carried out from ajoining rooms. The provider may wish to note that other treatment rooms were available but were not used.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service had good arrangements in place to ensure that it could meet the demand and needs of the patients that presented at the service with minimal delay. Staff told us that they had access to equipment needed to attend to patient's needs. Staff had access to information needed about local services available should a patient require specialist or secondary care.

Staff were aware of arrangements in place for responding to medical emergencies that may arise. However not all staff new where the emergency equipment was kept or had been provided with training on its use.

There were opportunities for patients to express their views about the service they received.

The service was accessible for patients with mobility difficulties and there were facilities for patient translation services for patients whose first language is not English.

Our findings

Patient involvement

Patients we spoke with were satisfied with their care and had not wanted to make a complaint. We saw information was provided for the public in the waiting areas in a folder kept on the desk. We saw that the complaints policy and process demonstrated openness and a way of monitoring trends. One example of changes made as a result of a patient complaint was staff that now proactively inform patients more frequently if there is a delay in their treatment. Another example included ensuring patients are aware there is not an x-ray service 24 hours a day.

We looked at the complaints log for the last year and did not see any trends. We saw that complaints had been dealt with promptly.

Staff on duty were both aware of how to share their concerns about employment issues or clinical issues. Both members of staff were aware of where to access the whistleblowing policy.

We were informed that Patient Experience Questionnaires were sent out to patients. This last survey was conducted in December 2013. This showed that patients thought the service was either excellent or good. Only one respondent had said the service was satisfactory.

Patients were also able to complete a touch screen satisfaction form at the exit of the centre. We were informed that any feedback relating to the out of hours service would be fed back to IC24.

Planning needs for local people

Integrated Care 24 (IC24) Limited provide a GP led 'out-of-hours' urgent care centre service at Queen Mary's Hospital, Sidcup. The service provided by IC24 operates between 21.45 and 08.00, seven days a week including bank holidays. There are other out of hours providers for members of the public to use between 18.30 and 08.00. These include a NHS 111 service (Grabadoc- run by a group of local GPs) and accident and emergency departments. The IC24 service does not receive referrals from these other out of hours services. The IC24 out of hours service is an additional resource for members of the public to access.

We spoke with staff on duty who told us they do not engage on a regular basis with other services or stakeholders. We spoke with patients who told us the service was well known in the area and that people knew it was there. One patient said they had phoned the 111 service (Grabadoc) and advised to go to A&E and that call centre staff did not know of the urgent care service. Other patients said it was more convienient to come to this service because they were seen quicker.

We saw a monthly Service Monthly Report conducted by IC24. This report looked at the average number of patients, which GP practice they are from, presenting complaints and percentages of referrals to secondary care. This shows that the organisation are planning and monitoring the needs of the service.

Accessibility

The service we were inspecting was located within an acute hospital which was managed by Oxleas NHS foundation trust. Access to the centre was by automatic double doors on a level access. There were toilet facilities for people with disabilities.

Staff had access to a telephone language line to help communicate with people whose first language was not English.

Are services responsive to people's needs?

(for example, to feedback?)

Changing needs

Staff working at the centre were unaware whether IC24 had a learning disability lead or dementia lead. The provider representative informed us that the clinical lead in the organisation would act as a link for staff with any questions.

Are services well-led?

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

Summary of findings

Staff who worked within the service described a supportive and open work environment and patients gave positive reviews of the service received. There were arrangements in place to learn from incidents and complaints which were shared with staff. Audits, surveys and incident reporting processes were undertaken. Findings from them were always acted on.

Regular staff received regular support and feedback as a way to discuss their performance and issues relating to their role. However, this was not always available for agency staff to formally raise any issues or concerns they might have about their work.

Our findings

Vision and strategy

The organisation was not well led at this site. Staff on duty said they felt supported by the organisation and were able to contact senior managers for advice and guidance.

There were clear clinical governance structures in place to monitor clinical effectiveness.

There were clear systems in place at the Organisation Headquarters for reviewing policies, procedures, systems and plans at the organisation. However, these were not always followed at the site we inspected. Staff we spoke with said any changes to policies and procedures were communicated via the intranet.

Leadership culture

Staff spoke highly of the ethos and support of the organisation. One member of staff commented that he felt the leadership 'fully supported' his development needs.

We spoke with agency staff who informed us they do not attend staff meetings and have not fed back any new ideas to the organisation. However, the doctor told us he attended regular 3 monthly meetings that included one of the medical directors and the staff and clinicians who worked at the centre. This usually occurred before one of the evening sessions and included clinical aspects.

Governance arrangements

Staff told us there were clear lines of accountability both during office hours and during the hours of operation.

There were effective systems for continuous review of performance of the service and clear clinical governance procedures in place.

Learning and improvement

Discussion with management staff at the head office confirmed that future planning for this service was difficult because of the nature of the short term uncertain contract. The current contract is extended by a few months at a time which makes staff recruitment and business planning difficult. However, the provider told us they continued with the routine quality assurance measures.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. The recruitment processes did not provide adequate safeguards to protect patients from being cared for or supported by unsuitable staff. The provider did not undertake adequate checks to ensure information from schedule 3 was available for all staff. Regulation 21. (a)(i) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. The provider did not have suitable arrangements in place to provide staff with an induction to enable them to deliver care and treatment to people safely. Regulation 23. (1)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements Management of Medicines** The provider did not have appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, and safe administration of medicines used for the purposes of the regulated activity. Regulation 13

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control 12 (1) (2a)

Patients and staff were not protected from the control the spread of a health care associated infection because of lack of handwashing between patients.

Regulation 12 (1) (2a)