Queen Elizabeth the Queen Mother Hospital Primary Care Hub

Inspection report

St. Peters Road
Margate
CT9 4AN
Tel: 01843225544
www.thanethealthcic.co.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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good.

This was the first time that this service had been inspected and rated.

The key questions are rated as:

Are services safe? – Good Are services effective? – Good Are services caring? – Good Are services responsive? – Good Are services well-led? – Good

We carried out an announced comprehensive inspection at the Queen Elizabeth the Queen Mother Hospital Primary Care Hub as part of our inspection programme.

The service which is run by Thanet Health Community Interest Company (THCIC), provides improved access to GP services to patients who are registered with the 14 GP practices within the NHS Thanet Clinical Commissioning Group (CCG). The improved access service gives patients the choice of accessing GP services at a place which may not be their own GP practice and at times when their own GP may or may not be open. The service is provided at various GP practices until from 6.30pm (normal GP closing time) until 8pm weekdays. On weekends it is provided from Queen Elizabeth the Queen Mother Hospital Primary Care Hub (the hub) from 8am to 8pm.

THCIC also provides an enhanced acute response team (E-ART). This service is currently a pilot project. The service involves putting primary care clinicians (GPs and nurses) to the front of the Accident and Emergency Department (A&E) assessing the patients' needs and initiating the appropriate treatment within minutes. It also serves to relieve the A&E from the patients who do not need emergency (rapid lifesaving) care.

The hub service and E-ART are provided from:

Queen Elizabeth the Queen Mother Hospital.

St. Peters Road.

Margate.

CT9 4AN.

Sixteen patients provided feedback about the services. Fifteen of these were positive about THCIC and one was partially negative. The comments praised the professionalism and care of the staff. They felt the service was a much needed one, and several mentioned the difficulty in getting GP appointments in the local area. The patients liked having 15 (as opposed to the standard 10) minute appointments. The negative aspect of one comment was critical of the time waiting to go into the appointment, though did not mention how long that waiting time had been.

Our key findings were:

- THCIC had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- THCIC routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where THCIC **should** make improvements are:

- Review systems of overall governance to improve effectiveness.

Overall summary

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.**
The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Queen Elizabeth the Queen Mother Hospital Primary Care Hub

The service is provided by Thanet Health Community Interest Company (THCIC). This is an independent company which holds a contract with the NHS Thanet Clinical Commissioning Group (CCG) to provide improved access GP services to the patients of the 14 GP practices in the CCG area. The service started in October 2018 and serves to a population of approximately 140,000 patients.

Appointments must be booked through the patients' own GP practice. THCIC provides a full range of GP services for both children and adults. However, the GP practices are made aware of which issues or conditions are not suited to be managed in a hub setting. For example, immunisation services are not provided.

THCIC run the services from an administrative headquarters at

Kent Innovation Centre

Millennium Way

Broadstairs

Kent

CT10 2QQ

This is not a registered location. THCIC is registered to provide the regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

On 14 November we visited the administrative offices, reviewed documents, records and spoke with staff. On 16 November we visited the registered location namely Queen Elizabeth the Queen Mother Hospital (the hub) at Margate

How we inspected this service

Prior to the inspection we contacted the commissioners of the service, the CCG about the service. We also gathered and reviewed information and statutory notifications that CQC hold about the service, and reviewed information that the provider sent to CQC.

During the inspection we talked with patients, interviewed staff, made observations and reviewed documents.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

We rated Safe as Good because:

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- THCIC conducted safety risk assessments. They had appropriate safety policies, which were regularly reviewed and communicated to staff. The policies outlined clearly who to go to for further guidance. Staff received safety information from THCIC as part of their induction and refresher training. THCIC had systems to safeguard children and vulnerable adults from abuse.
- THCIC worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- THCIC had only one formal employee who managed the administrative tasks and organised the staff rota. All other staff were directors of the company or sessional workers. THCIC had recruited the sessional workers appropriately and carried out all the necessary pre-employment checks. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- Almost all staff had received up-to-date safeguarding and safety training appropriate to their role. THCIC had identified some gaps in safeguarding and safety training, in that staff needed to complete refresher training. There was a system to prevent staff who had been so identified from booking shifts on the rota system. THCIC had safeguarding and safety training booked for 5 December.
- Staff we spoke with knew how to identify and report concerns. We saw evidence that such concerns had been correctly reported. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control as well as systems for safely managing healthcare waste.
- THCIC ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. All current equipment was under one year old, there were systems to help ensure that it would be maintained and calibrated annually.
- Services were provided from GP practices during the week and from Queen Elizabeth the Queen Mother Hospital (the hub) at weekends. THCIC had viewed the appropriate environmental risk assessments from these locations. These took into account the profile of people using the service and those who may be accompanying them and helped keep staff and patients safe. This included risk assessments and actions to prevent colonisation with Legionella bacterium. (Legionella is a term for a bacterium which can contaminate water systems in buildings).

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. There was information readily available to staff, and staff had received training, on how to identify and manage patients with severe infections, for example sepsis. The hub was located and was physically connected to the Accident and Emergency (A&E) department. There were informal arrangements to take severely ill patients directly into A&E without going through the triage system. Since the inspection we have seen documentation formalising these arrangements.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly.
- When there were changes to services or staff THCIC assessed and monitored the impact on safety.
- THCIC had appropriate indemnity arrangements.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Good

Are services safe?

- THCIC saw patients who were already registered with local GPs. There were no "walk-in" patients. Clinical staff had access to patients' medical records directly through the common IT system. They had access to any individual care records that were already in patients' medical records and could add to those records where appropriate. They were written and managed in a way that kept patients safe. The records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- THCIC had systems for sharing information with staff and other agencies to help enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- THCIC did not dispense or administer medicines nor did they stock or administer vaccines. Where appropriate, patients were issued with prescriptions for medicines which were dispensed elsewhere.
- THCIC kept prescription stationery securely and monitored its use.
- THCIC had carried out a medicines audit to help ensure prescribing was in line with best practice guidelines for safe prescribing.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- THCIC monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned, and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. THCIC learned, shared lessons, identified themes and acted to improve safety in the service. For example, we saw an incident where a patient was booked into the service, by reception staff at a GP practice, when they ought to have received an appointment sooner. It was raised as a significant event and investigated. We saw that it was discussed and disseminated amongst THCIC staff. However, there was no evidence that the event had been shared more widely, for example with staff at the local GP practices.
- THCIC was aware of and complied with the requirements of the Duty of Candour. THCIC encouraged a culture of openness and honesty. THCIC had systems for knowing about notifiable safety incidents. THCIC had an effective mechanism to disseminate alerts to all members of the team including sessional and agency staff.

When there were unexpected or unintended safety incidents:

- THCIC gave affected people reasonable support, truthful information and a verbal and/or written apology.
- They kept written records of verbal interactions as well as written correspondence if appropriate.
- THCIC acted on and learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

We rated effective as Good because:

Effective needs assessment, care and treatment

Thanet Health Community Interest Company (THCIC) had systems to help keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.

- THCIC assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. National and local guidelines were available via documents and links on the clinician's computer drive.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis. If further investigations were needed the patient's own GP undertook the further work.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.
- THCIC did not carry out tests of investigation but patients went back to their own GP for these services.
- THCIC did not refer patients to other services; with exception of two week wait referrals which were referred directly to secondary care providers rather than having to refer patients back to own GP.

Monitoring care and treatment

THCIC was actively involved in quality improvement activity.

- THCIC used information about care and treatment to make improvements and made improvements through the use of audits.
- There was clear evidence of action to resolve concerns and improve quality. For example, an audit of GP consultations was carried out. The audit compared the records from GP consultations with patients with the standards recommended across the urgent care and Out of Hours Services. The records were ranked, and comments added. Generally, records were found to be good. The results of the audit were discussed with the clinical staff concerned.
- There was an audit plan. However, THCIC had only been in existence since October 2018 and auditing was not fully developed. Two audits had been started. One was an audit of patients who were vulnerable who had made appointments but did not attend. The audit was partially completed and had not identified any cause for concern. The second audit was concerned with comparing the prescribing of certain antibiotics against national standards. It had proved difficult to separate out general primary care prescribing practices from the improved access element. This had been discussed with the medicines optimisation team at the NHS Thanet Clinical Commissioning Group (CCG). There was joint working to set up processes to more meaningfully extract the data.
- The commissioners, the CCG, carried out regular quality and safety reviews. We looked at some of the material the CCG used to check compliance with the contract. The CCG did not highlight any particular matters to the inspection team.

THCIC had a contract (1 October 2018 to 31 March 2021) with NHS Thanet CCG to provide, initially 22 hours per week of improved access GP services for patients in the CCG area. The contract was then extended and revised in April 2019 to provide 31 hours. The Improved Access scheme was run in parallel with E-art at the weekends. Clinical staff for each scheme were separately allocated but the same administration staff manage the patients at the hub.

Both the CCG and THCIC were satisfied that, in the main, the contractual hours required were being provided. The contract did not require THCIC to distribute the available hours evenly throughout the year.

- Utilisation of available appointments (booked appointments) had started slowly in October 2018 with 57% utilised. This rose consistently until by August 2019, the latest data available, 73% of all available appointments were booked.
- Did not attends (DNAs) were just over 4% of the available appointments and just over 6% of the booked appointments.

THCIC also provided an enhanced acute response team (E-ART). This put primary care clinicians (GPs and nurses) to the front of the Accident and Emergency Department (A&E) to triage and treat appropriate patients. It also served to relieve the A&E from the patients who did not need to be there.

Good

Are services effective?

The E-ART began, in April 2017, as a pilot offering a five hour a day shift from 7pm to midnight and 12 hours a day at weekends at the A&E at Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate. At the time at A&E was ranked as one of the worst preforming A&E departments, in achieving government targets in the country.

After a few weeks, the local hospital trust asked for the provision to be increased to 12 hours a day seven days a week. This was done, and the scheme has since been extended for two years.

There was an NHS Improvement visit in September 2019. That team was positive about the success of the scheme and mentioned that it as a national exemplar.

Current NHS data ranked the A&E at the QEQM in the top 40, in achieving government targets in the country.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. THCIC had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council / Nursing and Midwifery Council and were up to date with revalidation.
- THCIC understood the learning needs of staff and provided protected time and training to meet them. There was an up to date records of skills, qualifications and training. Staff were encouraged and given opportunities to develop. We looked at the training records of one employee and four sessional staff. THCIC had identified where there were gaps in training and had taken steps to address these. For example, there was a safeguarding update session planned for December 2019. Staff from THCIC were booked to attend. The training was open to any relevant staff working in the local health economy, whether they worked for THCIC or not. We saw that there were staff from other local GP practices who had booked to attend.

Coordinating patient care and information sharing

Staff worked and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, when making urgent referrals to secondary care.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. THCIC worked on the same IT system as the local practices and had access to the same records as if the patients were at their own GP practice.
- Patient information was shared appropriately (this included when patients were referred to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. Patient's GPs were made aware when they had been referred to other services.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice, so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- We saw from records that medical staff offered appropriate advice to patients when the opportunity arose.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance .

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- THCIC monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Thanet Health Community Interest Company (THCIC) sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- THCIC gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Telephone interpretation services were available for patients who did not have English as a first language. Information leaflets were available in easy read formats if required, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt staff were good listeners. Patients commented on the fact that each appointment was 15 minutes long and this gave them sufficient time to make informed decisions about the treatment options available.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand. For example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs.

Thanet Health Community Interest Company (THCIC) understood the needs of their patients and improved services in response to those needs. The provision was based on a needs analysis conducted in partnership with NHS Thanet Clinical Commissioning Group (CCG). It had determined that there was a need for approximately 37 hours of clinical appointment time for each 1000 people. The provision of service was built around the local GP practices, using this figure as a base. There was a basic intention that the number of appointments taken up by each local practice should reflect the population distribution but there was no intention to impose this. It was recognised that different practices had different needs.

- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, local GP practices providing evening services were selected, in part, for their accessibility. The Queen Elizabeth the Queen Mother Hospital Primary Care Hub (the hub) was adjacent to the Accident and Emergency Department, on the ground floor with good wheelchair access, accessible ramps and car parking.
- THCIC used patient surveys to try and identify areas, that patients felt could be improved. However, it was disappointed with the poor level of patient feedback and had plans to try and improve this.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment diagnosis and treatment. Weekend appointments could be booked up to six months in advance (though very rarely were). Weekday appointments could be booked up to four weeks in advance.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use. Patients booked appointments directly via their own GP practice.
- Referrals and transfers to other services were undertaken in a timely way. THCIC did not undertake more advanced diagnostic tests, for example sending blood samples for analysis or making standard referrals to secondary care. Such patients went back to their own GP for these facilities. THCIC did refer patients for two-week cancer referrals or access to rapid treatments such as those for acute heart conditions. We saw that there were systems to check that these referrals had been actioned.

Listening and learning from concerns and complaints

- Information about how to make a complaint or raise concerns was not readily available in that THCIC had no complaints leaflet. We raised this with THCIC and we saw a complaints leaflet, outlining the policies and processes, including how to complain and who to complain to had been produced by the end of the first day of the inspection. When we visited the hub on Saturday 16 November, two days later, we saw that there were complaints leaflets available. THCIC had not received any complaints in the first their first year since registration.
- There were processes to help ensure that THCIC learned lessons from individual concerns, complaints and from analysis of trends. There was provision for the numbers of these to be reported to the CCG. Discussion on complaints was a standing agenda item at senior management team meetings.
- THCIC was aware of and had systems to help ensure compliance with the requirements of the duty of candour. There had been no duty of candour incidents since THCIC had been registered with the Care Quality Commission.

Good

Are services well-led?

We rated well-led as Good because:

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, THCIC understood that a shortage of clinical staff was a key issue affecting the whole of the local health economy. Their strategy was to become the local provider of choice providing services to the local GP practice. Almost all the staff working at THCIC sites both in the local GP practices in the evenings and at Queen Elizabeth the Queen Mother Hospital Primary Care Hub (the hub) at weekends were local, many also working in GP practices. THCIC training days were available, at no cost, to any relevant Thanet clinical and administrative staff. Staff we spoke with who worked, as sessional staff, for THCIC expressed a strong sense of loyalty and commitment to keeping the service running and the rotas filled.
- There were regular board meetings at which operational and strategic issues were discussed. There were regular meetings with the commissioners, NHS Thanet Clinical Commissioning Group (CCG), to discuss current performance and plans.
- The organisation had been commissioned to provide an improved access to GPs service in an area where patients felt, and data supported (Thanet has the fourth highest ratio of patients to GPs in England), that it was difficult for patients to get GP appointments. Through an inclusive approach and showing personal commitment the leaders had, in the main, been successful in this.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- THCIC had effective processes to develop leadership capacity and skills, including planning for the future leadership of THCIC. There was a detailed three-year business plan available. Leadership plans were shared with staff.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. THCIC believed in delivering "superior quality integrated healthcare for the people who live and work in Thanet, preferably by people of or affiliated with Thanet. They had a realistic strategy and supporting business plans to achieve priorities.
- THCIC shared their vision, values and strategy with external partners, for example the CCG, the local hospital trust and the local Out of Hours provider.
- Staff, including the sessional staff we spoke with, were aware of and understood the vision, values and strategy and their role in achieving them. THCIC had held meetings for all the staff who supported the service such as the GP receptionists, GP and nurses where future developments were discussed and disseminated.
- THCIC monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They told us that they were proud to work for THCIC.
- THCIC focused on the needs of patients.
- Leaders and managers acted on behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents. THCIC was aware of and had systems to help ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. Staff were supported to meet the requirements of professional revalidation where necessary. All staff were considered valued members of the team. Sessional and locum staff were required to comply with mandatory training before working for THCIC. They were given access to online

training and time to complete it where appropriate. Such staff were kept informed of updates in policy, guidance and findings from significant events through the clinical and administrative THCIC IT system.
- There was a strong emphasis on the safety and well-being of all staff.
- THCIC actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management.

- THCIC was a young service,having been operational for just over a year. We saw that some areas of governance were still in development. There were processes and systems to support good governance and management, they were understood and generally effective. However, there was evidence that, on occasion, systems were only partially effective. For example, there had been a significant event were a patient had been booked into the hub when a quicker appointment would have been more appropriate. We saw that learning from this had been shared amongst the clinical staff. There was no evidence that the learning had been disseminated more widely, for example, to the staff making the appointments. The complaints policy stated that there would be complaints leaflets at each place where THCIC was delivered but there were not.
- There were many areas where governance was effective, management and filling of the rota system, focussing on GP practices with the lowest utilisation rates to try and increase uptake, steps to address the numbers of patient who did not attend for their appointments, reporting and monitoring to the CCG and a highly effective action log which focussed the management team on the identified priorities.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. There was action log which had identified various risks, for example, prescribing practices, coordination with the local mental health provider and how appointments were consistently across various practices. The log showed the actions taken to address them, for example, visiting all the practices and drawing up agreed pathways. The risks were discussed at the senior management level, with the CCG and other providers.
- THCIC had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. THCIC had only been registered for one year and, whist there was an audit plan, the number of audits completed was limited.
- THCIC had plans for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to help ensure and improve performance. Performance information was discussed with CCG and other stakeholders.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- THCIC used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- THCIC submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. THCIC had registered with the Information Commissioners Office.

Good

Are services well-led?

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- THCIC encouraged and heard views and concerns from the patients, staff and external partners and acted on them to shape services and culture. The public were involved, through the work done in conjunction with the CCG, in consultations prior to setting up THCIC. The hours and locations of the service were determined largely by local need and tried to build on existing services. There was a patient survey available at the hub. However, take up was poor and THCIC recognised this. There were plans, such as installing electronic devices at the point of contact, to try and improve patient participation.
- The leadership had an open-door policy, staff had input during meetings, one to one discussions and could feedback via during meetings. The senior management team visited GP surgeries and had channels of communication, such as the local medical council, to keep them aware of local demands and pressures.
- A report was sent to the commissioners, that is the CCG, monthly and representatives of THCIC met with the CCG every three months.
- THCIC was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- THCIC was very proactive in developing a website for the patients and the staff. For example, staff would be able to upload training documents and would automatically notified when the training needed to be renewed. There were plans to extend this across the practices so that there would be a reduced need for multiple copies of the same information.
- Where training was identified as being of benefit across the local economy THCIC made this available at no additional cost to relevant staff.
- THCIC were very involved as a provider and driver of the enhanced acute response team (E-ART) working at the Accident and Emergency Department (A&E) of the local General District Hospital. The E-ART put primary care clinicians (GPs and nurses) to the front of the A&E to triage and treat appropriate patients. There was evidence that the E-ART had substantially improved the performance of the A&E against the national performance data.