St Mary's Urgent Care Centre (Vocare Limited)

Quality Report

St Mary's Hospital
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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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection of St Mary's Urgent Care Centre (Vocare Limited) on 22 August 2017. This was to follow-up on a warning notice the Care Quality Commission served following an announced comprehensive inspection on 13 July 2017 when the provider was rated as inadequate for providing well-led services.

The warning notice, issued on 20 July 2017, was served in relation to regulation 17: Good Governance of the Health and Social Care Act 2008. The timescale given to meet the requirements of the warning notice was 18 August 2017.

The inspection on 13 July 2017 highlighted several areas where the provider had not met the standards of regulation 17: Good governance. We found:

- Systems and processes were failing to ensure accurate reconciliation of all patient x-rays.
- Systems and processes were failing to ensure effective clinical review of all x-rays.
- Systems and processes were failing to ensure effective recall of all patients with missed fractures.
- Systems and processes were failing to alert the provider to the backlog of x-ray clinical reviews.
- Systems and processes were failing to ensure that learning and outcomes from all categories of significant incidents were effectively shared and monitored.

At this inspection on 22 August 2017 we found that actions had been taken to improve the provision of well-led services in relation to the warning notice. Specifically the provider had:

- Undertaken a reconciliation of all patient x-rays in liaison with the hospital trust.
- Ascertained the number of patients whose x-ray had not been cross-checked by the urgent care centre (UCC) team and created a single patient database.
- Undertook a clinical review of each patient's consultation and x-ray result to identify any missed fractures.
- Contacted all patients by letter who had been identified as having a missed fracture.
- Re-established its standard operating procedure for the monitoring of x-rays.
- Implemented a daily risk management meeting within the UCC which included monitoring of x-rays.
- Re-established its systems and processes to ensure learning and outcomes from all categories of significant incidents were effectively shared with all staff and monitored to prevent the same thing happening again.

Summary of findings

At our previous inspection on 13 July 2017, we rated the provider as inadequate for the provision of safe, effective and well-led services with an overall rating of inadequate. The provider was placed into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Our inspection on 22 August 2017 focussed on the concerns giving rise to a warning notice being issued on the 20 July 2017. We found that the provider had taken action to address the breaches of regulation set out in the warning notice. However, the current overall inadequate rating will remain until the provider receives a further comprehensive inspection to assess the improvements achieved against all breaches of regulation identified at our previous inspection.

The comprehensive report published on 5 October 2017 should be read in conjunction with this report.

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 well-led?

During our inspection on 22 August 2017 we found the provider had made improvements to the provision of well-led services in relation to the warning notice. Specifically, the provider had:

- Undertaken a reconciliation of all patient x-rays in liaison with the hospital trust.
- Ascertained the number of patients whose x-ray had not been cross-checked by the urgent care centre (UCC) team and created a single patient database.
- Undertook a clinical review of each patient's consultation and x-ray result to identify any missed fractures.
- Contacted all patients by letter who had been identified as having a missed fracture.
- Re-established its standard operating procedure for the monitoring of x-rays.
- Implemented a daily risk management meeting within the UCC which included monitoring of x-rays.
- Re-established its systems and processes to ensure earning and outcomes from all categories of significant incidents were effectively shared with all staff and monitored to prevent the same thing happening again.

St Mary's Urgent Care Centre (Vocare Limited)

Detailed findings

Our inspection team

Our inspection team was led by:

This warning notice follow-up inspection was undertaken by a CQC inspector.

Background to St Mary's Urgent Care Centre (Vocare Limited)

St Mary's Urgent Care Centre (UCC) is commissioned by Central London Clinical Commissioning Group (CCG) to provide an urgent care service within north-west London. The service is located within St Mary's Hospital, Paddington which is run by Imperial College Healthcare NHS Trust. The urgent care centre premises are owned by the hospital trust.

The UCC service is provided by Vocare Limited who were awarded the contract in April 2016 following a procurement and tender process. The service had previously been run by the trust. Vocare, founded in 1996, is a national provider with headquarters in North East England and provides urgent care services to approximately nine million patients across the United Kingdom through urgent care centres, GP out-of-hours services and the NHS 111 services.

St Mary's UCC is managed and overseen by Vocare's London regional management structure headed by a regional director within the national corporate organisational structure. The local management team in the centre comprises a clinical director, lead nurse, and service operational manager. We were told the week prior to the inspection that the clinical director had resigned with immediate effect and the service operational manager had resigned and would not be available on the day of the inspection. The lead nurse position had been vacant since April 2017. We were informed by the provider that they had seconded to the centre, with immediate effect, an operational lead and lead nurse who had been part of the mobilisation of the service in April 2016. The secondment to the service would be full-time and for an initial period of three months. The local clinical director post would be covered by the Deputy Organisational Medical Director. The CCG told us they had been informed of this interim management structure arrangement. All interim staff were present at the inspection. The London regional director was not available at the inspection due to pre-planned leave.

The UCC is open 24 hours a day, seven days a week including public holidays. No patients are registered at the service as it is designed to meet the needs of patients who have an urgent medical concern but do not require accident and emergency treatment, such as non-life threatening conditions. Patients attend on a walk-in basis. Patients can self-present or they may be directed to the service, for example by the NHS 111 or their own GP. The service is GP-led with a multi-disciplinary team consisting of emergency department doctors, advanced nurse practitioners (ANPs), nurse practitioners (NPs), emergency nurse practitioners (ENPs) and emergency care practitioners (ECPs). The UCC provides assessment and treatment of minor illness and minor injuries for adults and

children. Reception at the point of entry to the service (A&E department) and paediatric initial assessment ('streaming') is currently sub-contracted to the hospital trust who provide these functions on behalf of the provider.

The provider is operating within a commissioned clinical and operational model for patients attending the UCC which requires patients to initially present to the A&E department where they are 'streamed' by a clinician to determine their care pathway. If the pathway is to be seen at the UCC then the patient is given an appointment and directed to separately located premises. The UCC is accessible by both an internal and external route within the hospital trust estate. The inspection team walked the patient journey and found that dependent on pace of walking, ambulatory capacity and whether an internal or external route had been chosen this could take between 10 and 30 minutes.

The patient activity at the UCC is approximately 55,000 patients per year.

Why we carried out this inspection

We undertook an announced focused inspection of St Mary's Urgent Care Centre (Vocare Limited) on 22 August 2017 to follow-up on concerns raised during a comprehensive inspection carried out on 13 July 2017, under Section 60 of the Health and Social Care Act 2008 as part of our regulatory function. At that inspection the provider was rated as inadequate for providing safe, effective and well-led services. Overall the provider was rated inadequate and placed into special measures. The full comprehensive report following the inspection on 13 July 2017 can be found by selecting the 'all reports' link for St Mary's Urgent Care Centre on our website at www.cqc.org.uk.

We undertook an announced focused follow-up inspection of St Mary's Urgent Care Centre (Vocare Limited) on 22 August 2017. This inspection was carried out to review in detail the actions taken by the provider in relation to the warning notice issued by the CQC on 20 July 2017 and to confirm that the provider was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with the Clinical Development Manager and the newly appointed Centre Manager.
- Reviewed systems and processes implemented for the monitoring, management and follow-up of x-rays.

Are services well-led?

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

Our findings

At our previous inspection on 13 July 2017, we issued a warning notice for good governance as the arrangements in respect of being a well-led service were in breach of regulation. Specifically we found the provider was failing to ensure an effective and timely process for the management of patient x-rays in line with their operating procedure.

All patients presenting to the Urgent Care Centre (UCC) with a suspected fracture had an x-ray undertaken by the hospital trust which was then interpreted by a UCC clinician and a diagnosis and appropriate management provided at the time of consultation. All x-rays were subsequently reported by the hospital trust radiologist and the UCC cross-checked the x-rays to ensure the appropriate diagnosis had been made by its clinicians and that any missed fractures were identified and follow-up treatment arranged. At our inspection on 13 July 2017, we found:

- Systems and processes were failing to ensure accurate reconciliation of all patient x-rays. The provider did not have accurate and full data of concerning patients who had undertaken an x-ray.
- Systems and processes were failing to ensure an effective clinical review of all x-rays following receipt of radiologist's clinical findings to ensure missed fractures were identified.
- Systems and processes were failing to ensure effective recall of all patients with missed fractures to ensure appropriate management was initiated.
- Systems and processes were failing to alert the provider to the backlog of x-ray clinical reviews. At the time of our inspection the provider estimated a potential backlog of 1,500 x-ray reports requiring review from the period May 2016 to March 2017. The provider was able to demonstrate on the day of our inspection that x-ray reviews were up-to-date for the period April to July 2017.
- Systems and processes were failing to ensure that learning and outcomes from all categories of significant incidents were effectively shared and monitored to prevent the same issue happening again.

Prior to our announced focused follow-up inspection on 22 August 2017, the provider submitted a comprehensive report and audit in response to the warning notice which clearly outlined the action it had taken in response to the findings of our inspection on 13 July 2017. The findings were also being investigated by the provider as a significant event in conjunction with its commissioners.

At our inspection on 22 August 2017 we reviewed the requirements of the warning notice and we found that governance arrangements in relation to the monitoring and review of patient x-rays had improved.

On the day of our inspection the provider was able to demonstrate that it had:

- Undertaken a reconciliation of all patient x-rays. The provider had liaised with the hospital trust and compiled a definitive list of all patients who had had an x-ray undertaken between May 2016 to March 2017.
- Compared the trust's patient list with its own to ascertain the number of patients whose x-ray had not been cross-checked by the urgent care centre (UCC) team and created a single patient database.
- Undertook a clinical review of each patient's consultation and x-ray result to identify any missed fractures.
- Contacted all patients by letter who had been identified as having a missed fracture. The letter included advice on the course of action, which included no further follow-up or medical follow-up to be sought. Details of a telephone helpline and email address was provided to enable patients to seek further advice.
- Re-established its standard operating procedure for the monitoring of x-rays. We asked the provider to demonstrate its operating procedure and saw a single database of all patients who had had an x-ray undertaken. We reviewed the data base and selected cases where a missed fracture had been identified. We saw that these patients had been contacted, advice given and details recorded.
- Implemented a daily risk management meeting within the UCC which included monitoring of x-rays. We reviewed minutes of meetings where these had been discussed.
- Re-established its systems and processes to ensure learning and outcomes from all categories of significant incidents were effectively shared with all staff and monitored to prevent the same thing happening again. It was not possible to determine the

Are services well-led?

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effectiveness or resilience of this process as our follow-up inspection was undertaken one month after the warning notice was issued. This will be reviewed as part of our full comprehensive follow-up inspection.