Barking Urgent Treatment Centre

Inspection report

Barking Hospital
Upney Lane
Barking
IG11 9LX
Tel: 02089111130
www.pelc.nhs.uk

Date of inspection visit: 25, 26, 29, 30 March, 14 and 15 April 2021
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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

This service is rated as requires improvement overall.

We carried out an announced comprehensive inspection of Barking Urgent Treatment Centre between 25 March and 15 April 2021. We are mindful of the impact of COVID-19 pandemic on our regulatory function. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

At this inspection we found:

- Leadership processes at the service were unclear.
- The organisation was not following it's own constitution, and was not able to demonstrate a clear vision, a positive culture or clear and consistent governance processes.
- The service had some systems to manage risk so that safety incidents were less likely to happen. However, we noted that infection control processes were not consistently followed, and that significant event processes were unclear.
- The service 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.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure that care and treatment is provided in a safe way to patients. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The areas where the provider **should** make improvements are:

- Ensure that the website is available to meet patient needs.
- Ensure that confidentiality is maintained at the streaming desk.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Overall summary

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team also included a further CQC inspector, CQC Inspection Manager, a GP specialist adviser, and two specialist advisors focussing on the corporate function of the organisation.

Background to Barking Urgent Treatment Centre

Barking Urgent Treatment Centre is an urgent treatment service available to anyone living or working in Barking and the surrounding areas in North East London. The service provides treatment of minor injuries and illnesses, and provides a streaming service in order that patients are transferred to the right service either within the Urgent Treatment or elsewhere.

The service is located on one level at Barking Hospital, Upney Lane, Barking, IG11 9LX and is accessible to those with limited mobility.

The service is delivered by Partnership of East London Cooperative (PELC) which is a not-for-profit social enterprise delivering NHS integrated urgent treatment services (including GP Out of Hours and Urgent Treatment Centres), to more than two million people across North-East London and West Essex.

The urgent treatment centre is open seven days per week between 8am and 10pm for patients who walk-in, self-refer, are referred by the NHS 111 service or are assisted in a chair by the ambulance service.

PELC provide doctors and streaming staff to the service. Streaming staff consist of doctors, nurses and paramedics. Other nurses are provided by North East London NHS Foundation Trust who subcontract nurse provision to PELC. Most of the clinical staff working at the service for PELC are either bank staff (those who are retained on a list by the provider) or agency staff.

CQC registered the provider to carry out the following regulated services at the service:

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

The service's website address is http://www.pelc.nhs.uk.

Requires Improvement

Are services safe?

We rated the service as requires improvement for providing safe services.

We carried out this announced comprehensive inspection between 25 March and 15 April 2021, and identified the following breaches of CQC regulation:

- Handwashing facilities were not in place at the primary location where streaming took place. In addition, we observed staff did not always wash their hands between patients despite the availability of hand washing gel, Although, the service had risk assessed the lack of handwashing facilities, this did not sufficiently mitigate the risks presented.
- The provider subcontracts nursing provision to North East London NHS Foundation Trust (NELFT). We were told that staff in the service as a whole had unified processes to follow in terms of reporting incidents through the datix system. This was not observed to happen in practice. The staff that worked for NELFT stated that they reported to their employing organisation, not the provider, which we saw was happening. That being the case, there was not a unified process for responding to and mitigating risks associated with incidents, which could potentially lead to incidents being missed.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service 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.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. 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).
- The service had a dedicated safeguarding lead, and systems were in place to enable staff to raise an alert.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- Handwashing facilities were not in place at the primary location where streaming took place. In addition, we observed staff did not always wash their hands between patients despite the availability of hand washing gel, Although, the service had risk assessed the lack of handwashing facilities, this did not sufficiently mitigate the risks presented.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

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. The COVID 19 pandemic had led to a number of surges in demand. Staff reported that the last year had been difficult, but that staffing requirement had been met. The organisation had escalation procedures in place in the event that surges occurred at very short notice.
- There was an effective induction system for temporary staff tailored to their role.

Requires Improvement

Are services safe?

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to 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.

Appropriate and safe use of medicines

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

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- The service had a lead pharmacist who had carried out audits to ensure that prescribing was in line with national or local guidelines.

Track record on safety

The service had a good safety record.

- The provider leased the premises from the hospital at which the site was based, who were were responsible for premises and safety checks. However, the service still carried out it's own comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the hospital Trust and the NHS 111 service.

Lessons learned and improvements made

Requires Improvement

Are services safe?

The process for reporting incidents was unclear, and staff at the service were not following a unified process.

- The provider subcontracts nursing provision to North East London NHS Foundation Trust (NELFT). We were told that staff in the service as a whole had unified processes to follow in terms of reporting incidents through the datix system. This was not observed to happen in practice. The staff that worked for NELFT stated that they reported to their employing organisation, not the provider. That being the case, there was not a unified process for responding to and mitigating risks associated with incidents.
- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- Where the service was aware of incidents, it learned and shared lessons, identified themes and took action to improve safety in the service. Learning from significant events was discussed at the integrated governance meeting, but we were told that not all relevant board staff, including council members, attended this. Information was cascaded to staff by a monthly newsletter.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations, including NELFT and the local 111 service.

Good

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to 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 supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Patients directed to the urgent treatment centre were streamed into urgent or routine. Routine patients could go back to the waiting room and wait for up to four hours. Patients who were assessed as urgent were seen more quickly. However, there was no monitoring mechanism to determine the time taken for a patient to see a navigator/streamer. Some of the staff that we spoke to were not aware of the urgent pathway, but we saw that in practice these patients were seen in the required timescale.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- If patient need or request dictated, streamers were able to assess patients in a consulting room
- Arrangements were in place to deal with repeat patients. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans, guidance an protocols were in place to provide the appropriate support. We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided.

- The service completed medicines audits, and specific audits to the service being offered. Prescribing audits were led by the lead pharmacist. The findings of audits were shared with staff. The audits that we reviewed included monitoring of antibiotics. This audit had completed two cycles and recommendations were shared through an organisational newsletter. This included a recommendation that non-branded antibiotics were prescribed where possible, as in some areas the audit had found brand named medicines were being prescribed at a higher cost.
- Further audits provided included those for "medicines of limited clinical value", an audit of the appropriate use of prescription documentation and an audit of opiate prescribing.
- The commissioners had set specific targets for the service, similar to National Quality Requirements which had previously provided a national framework for reporting. For example the service reported the number of patients who were seen withing 4 hours at the service. Between July 2021 and February 2021, the service reported between 98.2% and 100% against a 98% target.
- The service reported that 100% of patients who were repeat attenders were notified to their GP practice.
- The commissioning organisation for the service reported that they were satisfied with the organisation's performance.

Effective staffing

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

Good

Are services effective?

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. There was thorough list of mandatory training for all roles and this was monitored by the human resources department in conjunction with managers.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. Managers reported that this had been more difficult during the COVID 19 pandemic, but they still met with staff either face to face or via multimedia meeting as often as was practicable. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping 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. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Relevant staff had been provided with training in the Mental Capacity Act.

Good

Are services effective?

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.
- We observed both clinical and non-clinical staff treating patients with care, dignity and patience.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- A hearing loop was in place at the service for those patients for whom it would be of benefit.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- The streaming service at the site was based at a desk adjacent to the reception area. This was not a private space and conversations could be overheard.
- Staff respected confidentiality as far as the layout of the premises allowed.
- 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.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. The provider engaged with commissioners to secure improvements to services where these were identified.
- The urgent treatment centre offered step free access and all areas were accessible to patients with reduced mobility.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service, including those who were included on local safeguarding registers. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were mostly appropriate for the services delivered, but the streaming location was not private.
- At the time of the inspection, the service did not have an operational website, a banner which read "This website is under construction" was up in it's place. Some areas of the website were accessible, but others were not.

Timely access to the service

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

- Patients could access the service either as a walk in-patient, via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment.
- Patients were able to access care and treatment.
- The service operated from 8am until 10pm, seven days a week.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The organisation received between seven and ten complaints per month. We reviewed four complaints and found that they were satisfactorily handled in a timely way. Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. Learning from complaints was shared through the monthly 'safety matters' bulletin sent to the whole organisation.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Inadequate

Are services well-led?

We rated the service as inadequate for leadership.

We carried out this announced comprehensive inspection between 25 March and 15 April 2021. We found the following:

- Reporting lines for nursing staff was unclear. All of the nursing staff that we spoke to were unhappy with the culture and attitude of the PELC management.
- The organisation did not have corporate governance systems in place detailing a clear financial status for the business.
- Communication between the executive and non-executive team was not fit for purpose. Key members of staff with executive functions reported that they were not talking to one another.
- The organisation is not functioning as is detailed in their constitution. Council are not working within their remit as the non-executive function of the organisation.
- A vision document was shared which had been implemented just before the inspection. Some staff said that this was helpful, but others stated that there was little meaningful engagement in this.
- The role of members and the council was not clearly defined, and where requirements of the role were detailed they were not followed.
- Many staff that we spoke to said they felt disrespected and undervalued by both colleagues and senior staff, and there were difficult relationships at all levels.
- Multiple staff at all levels of the organisation told us that they had reported issues of bullying and harassment. They told us that where problems were reported, no action was taken.
- The structure of the organisation was unclear, and staff at all level provided an inconsistent picture of the corporate governance structure.
- The first members of staff that were seen by patients on arrival at the service were streamers. Is was unclear how the organisation had sufficient assurance that patients attending with conditions requiring urgent consultation were being reviewed sufficiently quickly.
- The organisation did not have sufficient information to determine whether or not it was delivering a good service. We were told that there was no IT strategy in place, and data was not presented in a holistic management report.

Leadership capacity and capability

The leadership structure at the organisation was unclear. We found that the organisation was not following it's own constitution

- The organisation was not functioning as detailed in their constitution. Council were not working within their remit as the non-executive function of the organisation. There were insufficient council members as required by the constitution of the organisation, no representation from staffing groups and social enterprise membership was not in place, therefore there was no challenge to council positions. The Company Secretary was unable to provide clear information on members of the organisation, or details of how the membership of the council had been democratically elected by members. The constitution required a range of roles including a Chair person, GP representatives, staff members and lay members. Only four GP roles were currently filled.
- The organisation did not have governance systems in place detailing a clear financial status for the business. No year-end finances had been submitted (as required by the Financial Conduct Authority) since 2017/18, and the last lodged finances were provided 13 months late. The service had not held an annual general meeting where finances could be reviewed by members in over a year.
- Council members chaired a number of governance meetings at the service, for example the financial oversight group. When interviewed, council members did not appear clear on the purpose of these meetings, and did not demonstrate

oversight of decisions made or the current status of the organisation. The organisation's structure mandated specific requirements relating to decision making. However, we noted that the organisation's council was making decisions that it was not authorised to make. Senior staff who we interviewed did not provide a consistent narrative for the level at which key decisions should be made.

- Key members of staff with executive functions reported that they were not talking to one another. We were also provided with numerous examples of bullying behaviour which had been reported but appeared not to have been managed, by both the executive team and other staff within the organisation. Council meetings and sub-committee meetings were not taking place as they should, for example the council who provided the non-executive function for the organisation had met only once in the last year, and there had been only one audit meeting in the past year.
- Terms of reference for meetings that staff regularly scheduled were unclear. The Integrated Governance Committee was utilised as a catch all for all business related matters in the absence of other meetings that ought to be taking place. The oversight of risk was limited. For example, there was limited information on the risk register given the current financial status of the organisation. When we discussed the financial risks faced by the organisation, staff were unable to quantify the level of risk, although all staff appeared to realise that it was an issue.
- All nursing staff are contracted by North East London NHS Foundation Trust (NELFT) with a NELFT representative in the management team, and a Director of nursing in PELC. However, the exact reporting line was found to be unclear, as staff that we spoke to did not provide a consistent narrative of how this worked. We were told by the executive team that there was a head of nursing at NELFT who reported to the director of governance at PELC. However, the nursing staff to whom we spoke were not clear about this. All of the nursing staff who we interviewed were unhappy with the culture and attitude of the PELC management. They reported that they were marginalised from decision making and had their limits of competence narrowed so that they were unable to undertake work for which they were trained.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.

Vision and strategy

The service did not have a clear strategy to deliver high quality care and promote good outcomes for patients.

- A new vision document had been incorporated immediately prior to the inspection. Some staff said that this was helpful, but others stated that there was little meaningful engagement in this. The business was not able to provide a long-term strategic plan. Interviews with executive and non-executive members of staff showed a vision of day to day management rather than a clear strategic outlook.
- Staff who we spoke to reported that the organisation was operationally rather than medically led. When we spoke to the executive team, they were of the view that the service was medically led. However, the majority of the middle managers and clinical staff who we interviewed did not agree that this was the case.
- The role of members and the council was not clearly defined, and where requirements were detailed, they were not followed. They were not fulfilling the standard non-executive role, and limited evidence was provided as to how they are challenging improvements. There was currently no chairperson of the board, and on the basis of our interviews, non-executive staff who had stepped in had not been clear on the requirements of chairing meetings and functions. For example, the chair of the finance committee had extremely limited knowledge of the financial status of the organisation.

Culture

The service and organisation providing it did not have a culture of high-quality sustainable care.

- The service focused on the needs of patients.

Inadequate

Are services well-led?

- Many staff that we spoke to said they felt disrespected and undervalued by both colleagues and senior staff, and there were difficult relationships at all levels. The relationship between nursing staff employed by NELFT and PELC was reported as being very difficult, with some staff from each organisation saying that staff at the other were not working effectively with them. Executive members of staff dismissed the concerns raised by the nursing staff.
- Multiple staff at all levels of the organisation told us that they had reported issues of bullying and harassment. They told us that where problems were reported to the executive team, no action was taken.
- Several senior staff that we spoke to provided examples of inappropriate behaviour in meetings. Several of the staff who we spoke to said this had a severely detrimental effect on their wellbeing. One senior manager told us how they actively avoid another senior manager due to previous levels of bullying and intimidation. Heads of departments also raised concerns about the bullying from two of the directors.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

Governance arrangements

The organisation did not have clear responsibilities, roles and systems of accountability to support good governance and leadership.

- The structure of the organisation was unclear, and staff at all level provided an inconsistent picture of the corporate governance structure. It was difficult to see where decisions were made, and we saw examples of decisions having been made without clear accountability, or consideration of other areas of the business. For example, a review of a change premises was undertaken without formal input from the finance team. Staff at all levels told us that there was insufficient strategic direction and governance systems.
- The first members of staff that were seen by patients on arrival at the service were streamers. Is was unclear how the organisation had sufficient assurance that patients attending with conditions requiring urgent consultation were being reviewed sufficiently quickly at very busy times.
- The council members in their role are designated to challenge the executive team in how the organisation was run. This was not happening. As representatives of the members, the council are responsible for this, and are in breach of their requirements as detailed in PELC's constitution.

Managing risks, issues and performance

The organisation did not have clear and effective processes for managing risks, issues and performance.

- There is no Board Assurance Framework to allow the council to maintain oversight of risks which could affect the delivery of the strategy.
- The unclear status of the organisation meant that the provider did not have processes to manage current and future performance of the service.
- Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints.
- Staff who we spoke to were not aware as to whether or not a major incidents escalation policy was in place.

Appropriate and accurate information

The service did not have access to clear information.

Inadequate

Are services well-led?

- We were told that there was no information technology strategy in place, and data was not presented in a holistic management report.
- We were told that there was no monitoring system in place to assure data integrity.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The service submitted data or notifications to external organisations as required.

Engagement with patients, the public, staff and external partners

The service had limited engagement with patients, the public, staff and external partners to support high-quality sustainable services.

- The organisation did not have formal meetings with patients group to discuss development of the business.
- Staff reported that they did not always feel listened to, and they felt that the organisation did not take action where they raised concerns.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Handwashing facilities were not in place at the primary location where initial navigation/streaming of the patients took place. In addition, we observed staff did not always wash their hands between patients despite the availbilty of hand washing gel, Although, the service had risk assessed the lack of handwashing facilities, this did not sufficiently mitigate the risks presented. • The provider subcontracts nursing provision to North East London NHS Foundation Trust (NELFT). We were told that staff in the service as a whole had unified processes to follow in terms of reporting incidents through the datix system. This was not observed to happen in practice. The staff that worked for NELFT stated that they reported to their employing organisation, not the provider, which we saw was happening. That being the case, there was not a unified process for responding to and mitigating risks associated with incidents, which could potentially lead to incidents being missed. **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Reporting lines for nursing staff was unclear. All of the nursing staff that we spoke to were unhappy with the culture and attitude of the PELC management. • The organisation did not have corporate governance systems in place detailing a clear financial status for the business.

This section is primarily information for the provider

Enforcement actions

- Communication between the executive and non-executive team was not fit for purpose. Key members of staff with executive functions reported that they were not talking to one another.
- The organisation is not functioning as is detailed in their constitution. Council are not working within their remit as the non-executive function of the organisation.
- A vision document was shared which had been implemented just before the inspection. Some staff said that this was helpful, but others stated that there was little meaningful engagement in this.
- The role of members and the council was not clearly defined, and where requirements of the role were detailed, they were not followed.
- Many staff that we spoke to said they felt disrespected and undervalued by both colleagues and senior staff, and there were difficult relationships at all levels.
- Multiple staff at all levels of the organisation told us that they had reported issues of bullying and harassment. They told us that where problems were reported, no action was taken.
- The structure of the organisation was unclear, and staff at all level provided an inconsistent picture of the governance structure.
- The first members of staff that were seen by patients on arrival at the service were navigators/streamers. Is was unclear how the organisation had sufficient assurance that patients attending with conditions requiring urgent consultation were being reviewed sufficiently quickly.
- The organisation did not have sufficient information to determine whether or not it was delivering a good service. We were told that there was no IT strategy in place, and data was not presented in a holistic management report.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.