King George's EUCC

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall (Previous inspection April 2018 – Inadequate).

We carried out an announced comprehensive, follow up inspection at King George's Emergency Urgent Care Centre (EUCC) on 14 March 2019.

CQC previously inspected the service on 5 April 2018 and asked the provider to make improvements because although the care being provided was responsive, it was not being provided in accordance with the relevant regulations relating to safe, effective, caring and well led care. Specifically, we found the provider had breached Regulation 12 (1) (Safe care and treatment) and Regulation 17 (1) (Good governance) of the Health and Social Care Act 2008. This was because of an absence of appropriate clinical equipment and systems to safely assess and monitor patients. We also noted a lack of appropriate systems for sharing learning from safety incidents and for ensuring governance arrangements operated effectively.

Two Warning Notices were served and the service was placed into Special Measures. Shortly thereafter the service wrote to us to tell us what they would do to make improvements. We undertook this comprehensive inspection to check the service had followed their plan and to confirm they had met the legal requirements.

At this inspection, the key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Requires Improvement

Are services responsive? – Good

Are services well-led? – Good

At this inspection we found:

•Action had been taken since our last inspection such that leadership and governance arrangements now supported the delivery of high-quality and person-centred care.

•Action had been taken since our last inspection to ensure that when safety incidents happened, learning was shared internally with relevant people. For example, a monthly Governance Committee had been established to learn from safety incidents and improve safety; and a staff bulletin established to share this learning.

•Action had been taken since our last inspection to improve how the service assessed and monitored patients. This included availability of appropriate clinical equipment and introduction of new protocols and training to support how clinicians 'streamed' or assessed patients. However, we noted the new protocols did not record how long patients waited in the queue or include formal arrangements for prioritising patients who were frail or acutely ill.

•Action had been taken since our last inspection to improve the service's physical layout and make it more conducive to maintaining patients' privacy, although we noted conversations in the service's new initial assessment room could be overheard. We saw that staff involved and treated people with compassion, kindness, dignity and respect.

•There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

•Continue to liaise with it's NHS Trust Landlord to further improve how the physical layout ensures patients' privacy.

- Continue to further develop queue management arrangements, so as to more precisely measure how long patients wait in the queue.

•Take action to ensure electronic patient feedback terminals are available in languages other than English.

•Take action to ensure appropriate filing systems are in place for staff pre-employment checks and training records.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

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, a CQC pharmacist specialist advisor and a CQC governance specialist adviser.

Background to King George's EUCC

King George's Emergency Urgent Care Centre (EUCC) is an urgent care service available to anyone living or working in Ilford and the surrounding areas in the London Borough of Redbridge, East London.

The service is co-located on one level with the Emergency Department of King George's Hospital based at Barley Lane, Goodmayes, Ilford, Essex and is fully accessible to those with limited mobility. The service is delivered by The Partnership of East London Cooperatives (PELC) Ltd.

The centre is a 24/7 NHS walk-in service for patients who consider their condition is urgent enough that they cannot wait for the next GP appointment and initially entails a clinician assessing and then 'streaming' or directing a patient for treatment by the most appropriate clinician: for example at the hospital's emergency department or at the EUCC.

On site, the EUCC service is led by a service manager and a lead GP who has oversight of the urgent care centre.

The service employs doctors, nurses and streaming nurses. Most staff working at the service are either bank staff (those who are retained on a list by the provider) or agency staff.

The urgent care service is open 24 hours a day and on average sees 900 patients per week. Patients may contact the urgent care service in advance of attendance but dedicated appointment times are not offered.

This inspection was to confirm the provider had carried out their plan to meet the legal requirements in relation to breaches in regulations that we identified in our previous inspection on 5 April 2018.

CQC register the service to carry out the following regulated services:

•Treatment of disease, disorder or injury

•Diagnostic and screening procedures

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

Good

Are services safe?

When we inspected in April 2018, we rated the service as inadequate for providing safe services because clinical equipment was not readily available and because learning from safety incidents did not include all relevant people.

At this inspection, we confirmed that appropriate clinical equipment was available and that protocols had been revised so that when safety incidents happened, learning was shared with relevant people.

We rated the service as good for providing safe services.

Safety systems and processes

We looked at the systems in place 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.

•We were told the provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate; and that 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. However, none of the three clinical streamer personnel records we reviewed contained references or DBS checks. Shortly after our inspection we were advised that this was an administrative oversight and that all necessary staff checks were on file.

•All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.

•There was an effective system to manage infection prevention and control.

•The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However, we noted the blood glucose monitors in use were not multi-patient devices which meant there was a potential for inaccurate readings. When this was highlighted, the service told us they would immediately order devices appropriate for multi-patient testing.

•There were systems for safely managing healthcare waste.

Risks to patients

We looked at 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 temporary staff tailored to their role.

•In November 2018, the service introduced a protocol to deal with surges in demand, based on the Operational Pressures Escalation Level (OPEL) system used across England for NHS Trusts. The protocol required reception staff and streamers to regularly observe queue length and on the day of our inspection we saw this was happening. However, the new protocol did not time how long people waited in the queue.

•Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.

•When we inspected in April 2018, we highlighted concern regarding the level of detail contained in the service's "Clinical Policy for Emergency and Urgent Care" streaming document, in that it failed to reference sepsis. At this inspection, we noted that protocols were now in place to help staff and clinicians identify and manage patients with sepsis.

•Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

•When there were changes to services or staff the service assessed and monitored the impact on safety.

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?

•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

We looked at systems for the appropriate and safe handling of medicines.

•The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.

•The service carried out regular medicine audits 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.

Track record on safety

When we inspected in April 2018, the service's streaming process was not always reliable or appropriate to keep people safe because blood pressure monitors and child oxygen saturation probes were not readily available and because the streaming process included unnecessary delay between clinical staff visually assessing a patient and a healthcare assistant taking their observations.

At this inspection, we confirmed that appropriate clinical equipment was available and protocols had been revised so a clinical streamer undertook all clinically relevant observations. When we spoke with a streamer they described the new protocol and told us clinical leads were supportive. We saw the new protocols were readily available to staff.

•The service monitored and reviewed activity. It had recently revised its risk register which helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

•We noted the service had acted since our April 2018 inspection and that there was now a designated lead person and a system for receiving and acting on safety alerts.

•Joint reviews of incidents were carried out with partner organisations, including the hospital's A&E department.

Lessons learned and improvements made

We looked at how the service learned and made improvements when things went wrong.

•When we inspected in April 2018, we could not be assured that learning from safety incidents included all relevant people. We asked the provider to take action and at this inspection we noted the service had revised it's Incident Policy and also introduced a staff "safety matters" bulletin to disseminate learning from incidents. A Governance Committee had also been established and minutes confirmed this forum was used to share lessons from incidents, identify themes and act to improve safety.

•When we spoke with clinical and administrative staff, they told us how they were kept informed about safety incidents and associated changes to protocols. This included a restricted access, smart phone based social media group to enable doctors and streaming staff to discuss and share learning from incidents. They also understood their duty to raise concerns and report incidents and near misses. Managers supported them when they did so.

•We noted that 166 incidents had been reported since April 2018. The Chief Executive Officer spoke positively of a cultural shift in the service, whereby all staff were actively encouraged to record incidents.

•We reviewed five incidents which took place between August and November 2018. Records showed these incidents had been discussed and shared internally; and had resulted in improved patient safety. For example, basic life support training requirements for streaming staff had been enhanced after a patient collapsed in reception.

•Actions had been taken since our April 2018 inspection to ensure learning from external safety events and patient safety alerts was effectively disseminated to all members of

Good

Are services safe?

the team including sessional and agency staff. For example, we noted the service had set up a smart phone based restricted access social media group for doctors and streaming staff to receive patient safety alerts.

•The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. For example, a review of a safety incident with Hospital Trust staff had prompted the service to increase the number of clinical streaming staff between 3am and 8am.

Good

Are services effective?

When we inspected in April 2018 we rated the service as requires improvement for providing effective services because the process for assessing and directing a patient for treatment (known as 'clinical streaming') did not enable the service to safely monitor and manage risks.

At this inspection, we noted new protocols and an advanced competency assessment had been introduced, to improve how clinicians assessed and monitored patients.

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 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 people's needs were met. The provider monitored these guidelines were followed.

•Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.

•Care and treatment were delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.

•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 protocols were in place to provide the appropriate support.

•Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

•The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, by auditing doctors' consultations and nurses' streaming sheets. Where appropriate clinicians also took part in local and national improvement initiatives. For example, just before our inspection the service was visited by a national quality improvement organisation which was benchmarking the service against other urgent care services in England.

•The service used key performance indicators (KPIs) that had been agreed with its clinical commissioning group to monitor their performance and improve outcomes for people. The service shared with us the performance data from April 2018 to February 2019 that showed:

•The service was meeting its target for ensuring that 100% of people treated at the service had their episode of care reported to their GP within 48 hours of discharge.

•There were areas where the service was outside of the target range for an indicator. Where the service was not meeting the target, the provider was aware and we saw evidence that attempts were being made to address them. For example, between April 2018 - December 2018, performance on the percentage of people who had had the completeness and accuracy of their NHS numbers checked ranged between 84% and 93% (which was below the target of 95%). The provider told us this was due to a connectivity issue between it's IT system and that of it's NHS Trust landlord. This was resolved in January 2019 and performance reached the target 95%.

•The service made improvements using completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

In January 2019, the service revised its streaming protocol so that for example, streamers undertook all clinically relevant observations. However, the new protocol did not allow for precise monitoring of how long patients were waiting in the queue. Shortly after our inspection, we were advised that although the service's OPEL system provided some indication of waiting times, new ticket machines had been ordered so that waiting times could be measured more precisely.

Effective staffing

We looked at whether staff had the skills, knowledge and experience to carry out their roles.

•The provider had an induction programme for all newly appointed staff and which covered streaming and observation pathways.

Good

Are services effective?

•The provider ensured 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.

•Staff were encouraged and given opportunities to develop.

•An advanced streaming competency assessment had been created for all clinical streaming staff.

•The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. 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.

•There was a clear approach for supporting and managing staff when their performance was poor or variable through for example targeted audits where a concern had arisen through a complaint or through routine audit.

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 patients' registered GPs, so 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 care was delivered in a coordinated way and considered 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.

•The service identified patients who may need extra support.

•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.

•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.

Requires improvement

Are services caring?

When we inspected in April 2018, we rated the service as requires improvement for providing caring services because the premises lacked sufficient space for initial patient assessments to be conducted in private. At that time, the service was finalising plans with it's NHS Trust landlord to undertake the required refurbishment works.

At this inspection, the works had been completed and we saw that initial patient assessments now took place in a dedicated room. However, a privacy curtain served as a door and conversations could easily be overheard from the streaming queue.

We rated the service as requires improvement 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.

•All ten of the patient Care Quality Commission comment cards we received were positive about the service experienced.

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 patients and their carers can access and understand the information they are given):

•Interpreting 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.

•Patients told us through comment cards, they felt listened to and supported by staff.

•For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.

•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

When we inspected in April 2018, we noted the premises were inappropriate for clinical streaming because they lacked sufficient space to enable initial patient assessments to be conducted in private. At that time, the service was finalising plans with it's NHS Trust landlord to undertake the required refurbishment works. At this inspection, we saw the works had been completed and initial patient assessments now took place in a dedicated room. However, we noted that a privacy curtain served as a door and conversations could easily be overheard from the streaming queue.

•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.

•The service monitored the process for seeking consent appropriately.

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 engaged with commissioners to secure improvements to services where these were identified. For example, the service provider was also commissioned to provide an out of hours service from the same hospital location.

•The urgent care centre offered step free access and all areas were accessible to patients with reduced mobility.

•The waiting area for the urgent care centre was large enough to accommodate patients with wheelchairs and pushchairs; and also allowed for access to consultation rooms.

•There was enough seating for the number of patients who attended on the day of the inspection.

•The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service such as alerts about a person being vulnerable or on the end of life pathway.

•Toilets were available for patients attending the service, including accessible facilities with baby changing equipment.

•Beverages were available.

•However, the electronic patient feedback terminal located on the premises was only available in English and not in other languages commonly spoken in the locality.

Timely access to the service

We looked at whether patients were able to access care and treatment from the service within an appropriate timescale for their needs.

•Patients were able to access care and treatment at a time to suit them. The service operated 24 hours a day, seven days a week.

•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 generally seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. We noted this system was not governed by a written protocol. The receptionists informed patients about anticipated waiting times.

•Patients had timely access to initial assessment, diagnosis and treatment. We saw the most recent local KPI results for the service (April 2018 – February 2019) which showed the provider was meeting the following indicator:

oBetween 97% and 100% of people who arrived at the service completed their treatment within four hours. This was above the target of 96%.

•Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

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. We noted 75 complaints had been received since April 2018. We reviewed three complaints and found they were satisfactorily handled in a timely way. For example, we saw evidence clinicians' statements had been sought, that complainants had, where appropriate, received an apology and that learning was routinely shared with staff. Issues were also investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.

•The service learned lessons from individual concerns, complaints and from analyses of trends. It acted as a result to improve the quality of care.

Good

Are services well-led?

When we inspected in April 2018, we rated the service as inadequate for providing well led services because leaders were unaware of safety risks associated with the service's streaming process. Also, governance arrangements for medicines audits and for learning from safety incidents were not effective; and there was minimal engagement with people who used the service (for example through patient surveys).

At this inspection, we noted several changes in personnel to the service's senior leadership team and that a range of new policies, procedures and activities had been introduced to ensure safety. Appropriate governance arrangements had also been introduced to provide assurance that new policies and procedures were operating as intended; and patient surveys were now routinely undertaken.

We rated the service as good for leadership.

Leadership capacity and capability

Shortly after our last inspection report was published, the service made several changes to it's senior management team including the appointment of a new interim Chief Executive Officer (whom we were later advised had been offered a two year fixed term contract), a new Medical Director, a seconded Director of Nursing and a new Urgent Care lead doctor. Leaders had the capacity and skills to deliver high-quality care. For example:

•A new strategy had been implemented and leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.

•Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

•Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

•Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.

•The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

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. The service had a realistic strategy and supporting business plans to achieve priorities.

•The service developed its vision, values and strategy jointly with patients, staff and external partners.

•Staff were aware of and understood the vision, values and strategy and their role in achieving them.

•The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.

•The provider monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality care.

•The service's interim Chief Executive Officer spoke of a culture where staff were respected, supported and valued. A clinical streamer (who had worked for similar services across London) spoke positively about how senior managers routinely thanked staff for their work. They were proud to work for the service.

•Action had been taken to refocus the service on the needs of patients.

•Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

•Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, we saw the service undertook root cause analyses of serious incidents and held round table discussions with relevant stakeholders. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

•Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence these would be addressed.

•There were processes for providing all staff with the development they needed. This included appraisal and career development conversations.

Good

Are services well-led?

•Clinical streaming staff were considered valued members of the team.

•There was a strong emphasis on the safety and well-being of all staff.

•The service 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.

•The leadership actively shaped the culture of the service through effective engagement with stakeholders. For example, performance was benchmarked against other urgent care services in England and the service's significant events analyses routinely involved round-table discussions with local stakeholders.

Governance arrangements

When we inspected in April 2018, governance arrangements for clinical streaming and safety incidents did not always operate effectively. At this recent inspection:

• Protocols had been reviewed and revised, such that staff were now clear on their roles and accountabilities in respect of clinical streaming, incident reporting and other service areas. For example, clinical streaming protocols now included reference to sepsis and a "safety matters" bulletin was routinely circulated to staff. A restricted access social media group had also been set up to help disseminate learning from safety incidents.

•Leaders had established proper policies, procedures and activities to ensure safety and had also established a monthly Governance Committee for oversight and to assure themselves these policies and procedures were operating as intended.

•With the exception of streaming protocols for formally prioritising patients in acute need and for monitoring how long people waited in the queue; structures, processes and systems were clearly set out, understood and effective.

Managing risks, issues and performance

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

When we inspected in April 2018, we could not be assured an effective risk management system was in place. This was because the service's risk register was not kept up to date and because of concerns regarding how the service learned from safety incidents and disseminated safety alerts. At this inspection:

•The service had established a monthly risk management meeting to identify, understand, monitor and address current and future risks, including risks to patient safety. The group regularly reviewed the service's risk register and took appropriate mitigating actions as necessary. For example, minutes showed that following a patient safety incident, the group had approved streaming staff receiving additional intermediate life support training, to mitigate against future risks.

•The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations and prescribing decisions. Leaders had oversight of external safety alerts, incidents and complaints.

•Leaders also had a good understanding of service performance against local key performance indicators. Performance was regularly discussed at senior leadership team and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.

•Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

•The providers had plans in place and had trained staff for major incidents.

•The provider implemented service developments with input from clinicians, to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

•Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

•Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Good

Are services well-led?

•The service 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.

•The service used information technology systems to monitor and improve the quality of care.

•The service submitted data or notifications to external organisations as required.

•There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

When we inspected in April 2018, we noted minimal engagement with people who used the service (for example through patient surveys). At this inspection we noted the service had installed a patient feedback terminal which enabled weekly feedback to be collated and analysed on indicators such as the extent to which staff showed compassion and the extent to which staff showed dignity and respect.

Staff were also able to describe to us the systems in place to give feedback such as during supervision meetings or at team meetings. Staff who worked remotely were engaged and able to provide feedback through a restricted access social media group.

Continuous improvement and innovation

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

•There was a focus on continuous learning and improvement at all levels within the service. For example, just before our inspection the service was visited by a national quality improvement organisation which was benchmarking the service against other urgent care services in England.

•Staff knew about improvement methods and had the skills to use them.

•The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

•Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

•There was a strong culture of innovation evidenced by the number of pilot schemes in which the provider was involved. There were systems to support improvement and innovation work.