Queens Urgent Treatment Centre

Inspection report

Rom Valley Way
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Essex
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Date of inspection visit: 5 to 13 Febraury 2020
Date of publication: 07/04/2020

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

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

Overall summary

We carried out an announced comprehensive inspection of Queens Urgent Treatment Centre, Rom Valley Way, Romford, Essex, RM7 0AG on 5, 12 and 13 February 2020.

We have taken the decision not to rate this service because Queens Urgent Treatment Centre's date of registration with the CQC was 23 January 2020.

At this inspection we found:

- The service was led by a chief executive who was supported by a senior leadership team that reported to the PELC council. Local clinical and performance meetings fed into the integrated clinical governance committee, management executive team, and finance, audit and remuneration meetings which in turn fed into the PELC council meetings (Board). We found the service held monthly integrated governance committee meetings.
- The service mostly had clear systems to keep people safe and safeguarded from abuse.
- The service learned and made improvements when things went wrong and responded to and learnt from complaints.
- To improve the service, staff had completed 24 audits over a period of 18 months, two of the audits were two cycle audits.
- The provider has increased the number of patients seen in the urgent treatment centre from 41% to over 70% since taking over the service, which resulted on less pressure in the A&E department at the hospital.
- The service was open 24 hours a day, seven days a week, and adjusted their staff according to patient demand.
- At the time of our inspection, the management team did not have effective oversight of staff recruitment and training. However, following the inspection, the provider employed a human resource compliance officer whose role was to ensure that all staff have completed the appropriate training for their role and to ensure the service's recruitment system is effective.
- The system for the management of the emergency medicines and patient group directions used by non-prescribers was sometimes not fully effective or fully embedded. However, immediately following the inspection, the provider took immediate action to ensure an improved and effective system.
- The protocols in place did not provide the streamers with a consistent approach to aid the safe direction of patients. In addition, staff were not always following the guidance provided and completing observations prior to streaming patients to all areas. However, immediately following the inspection, the provider submitted information to demonstrate that they had introduced new streaming guidance regarding children. They also, summitted an action plan that included to review all the streaming guidelines, to ensure adequate detail was provided by the patient and recorded. In addition, they had changed the patient record system to ensure staff always completed and documented the necessary observations.
- The provider had introduced a streaming competencies framework in 2018, however the management team had failed to ensure this system was adhered to and completed by all required staff. In addition, we found a new process for clinical supervision for streaming staff had been commenced, but the process was not formalised or embedded. However, immediately following the inspection, the provider submitted an action plan that included to further develop a performance management process for streamers, improving training, and review the competency framework. The provider has also changed the patient record system to ensure streaming staff complete and record patient observations. In addition, the provider was planning to change the patients notes audit system so that it included streamers record keeping.
- The Trust, where the service was located managed the prevention of infectious diseases at the service, however, we found the service did not always have full oversight of these arrangement.
- Although, the management team robustly monitored patient feedback and provided the information to the local clinical commissioning group, we were not provided with any evidence of how they had responded to lower patient survey results.

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

Overall summary

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

(Please see the specific details on action required at the end of this report)

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

- Follow the correct system for the review of non-medicine Central Alerting System (CAS) and Medicines and Healthcare products Regulatory alerts (MHRA).
- Continue to improve the privacy and dignity of patients in the waiting room.
- Improve the process in place to navigate patients to the major's lite service so that it includes information regarding the streaming process, colour coding and is available in other languages.

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Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. On 5 February the team consisted of the lead inspector and a second CQC inspector. On 12 February the team included the lead CQC inspector, a GP specialist adviser and two CQC team inspectors. On 13 February the team consisted of the lead inspector and a GP specialist adviser.

Background to Queens Urgent Treatment Centre

Queens Urgent Treatment Centre (QUTC) is an urgent treatment service available to anyone living or working in Ilford and the surrounding areas in the London Borough of Romford and North East London. The service consists of a minor injuries' unit, a primary care minor illness unit, and a streaming service. The purpose of streaming is to quickly determine the most appropriate place for a patient who walks through the front door of an A&E co-located in an urgent treatment centre to be assessed or treated. This includes sending the patient to the right department within the hospital or redirecting them off-site to a more appropriate setting.

The service is co-located on one level with the emergency department of Queens Hospital based at Rom Valley Way, Romford, Essex, RM7 0AG 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 (NHS 111, Clinical Assessment, GP Out of Hours and Urgent Treatment Centres), to more than two million people across East London and West Essex.

The urgent treatment centre is a 24/7 NHS service for patients who walk-in, self-refer, are referred by the NHS 111 service or are assisted in a chair by the ambulance service.

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 treatment service is open 24 hours a day and on average sees over 4,000 patients per month. Dedicated appointment times are not offered.

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.

Are services safe?

Safety systems and processes

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

- The service had two clinical leads for safeguarding adults and children and had clear systems in place to enable staff to raise an adult or child safeguarding alert.
- The lead GP had carried out an audit of the safeguarding alerts to review the outcomes and offered safeguarding supervision to the locum GPs.
- The service had made 62 safeguarding referrals between 1 April 2019 and the date of the inspection.
- At the time of the inspection we found the provider could not provide evidence that all staff had completed the appropriate safeguarding training. Following the inspection, the provider employed a human resource compliance officer, whose role was to ensure that all staff had completed the appropriate training for their role. Staff had completed prevent training.
- Although the premises appeared clean, we found on the day of the inspection that, the management team, did always have oversight of the management of prevention of infectious disease at the service, which were managed by the Trust. For example, although the management team provided us with a completed hand hygiene audit dated 20 January 2020. On the day of the inspection, the management team were unable to provide a copy of the most recent risk assessment for the control of infectious diseases. We also saw the cleaning agency did not use colour coded mops for specific areas to prevent the spread of infections from a dirty (toilets) to clean area (clinical rooms).
- The service was not aware of all of the Green Book guidance for immunisations of healthcare staff. Records were not kept of staff immunisations for Diphtheria, Tetanus and Polio. Following the inspection, the provider submitted evidence that they had now sought this information from staff.
- On 5 February 2020, we reviewed the recruitment systems to ensure staff were suitably recruited to their roles. At the time of the inspection, due to the change of computer software, the provider did not have an oversight of staff recruitment. Following the inspection, the provider submitted a spreadsheet that demonstrated all staff had DBS. And has employed a human resources compliance officer to ensure to ensure an effective recruitment system.
- Disclosure and Barring Service (DBS) checks undertaken where required and registration checks. (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
- Staff who acted as chaperones had received a DBS check. However, we noted the provider did not have evidence whether some reception staff had completed their chaperone training.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed and an effective system in place for dealing with surges in demand. For example, the provider in conjunction with the trust followed the Operational Pressures Escalation Levels Framework (OPEL). The provider held a daily gold meeting with the Trust to review the pressures and allocate staff. In addition, we saw staff numbers were reviewed as part of the reporting process to the local clinical commissioning group.
- There was an effective induction system for temporary staff tailored to their role. The provider had a GP welcome pack for GPs working in the primary care centre.
- Most staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. There was information about sepsis in the reception areas.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. The service had a 'roving' streamer who monitored the waiting rooms to ensure patients were safe.
- 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 did not always have the information they needed to deliver safe care and treatment to patients.

Are services safe?

- Our records review of 15 patients who were streamed at the centre identified that the streamers did not always record sufficient information in the patient records to explain their decision to direct patients to services. For example, we saw one patient was streamed to minor injuries when they had a minor illness and subsequently waited over two hours to be seen.
- Clinicians did not always make appropriate referrals in line with protocols and up to date evidence-based guidance. A review of patients' records found that a few had not been referred either at the appropriate level of priority or to the correct department.
- Immediately following the inspection, the provider submitted information to demonstrate that they had introduced new streaming guidance regarding children. They also summitted an action plan that included reviewing all the streaming guidelines, and ensuring adequate detail is given and recorded by streamers. In addition, they have amended the computer patient record system to ensure that staff have to complete and record basic observations during streaming.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The service used a computer system that enabled the sharing of the clinical consultation. When streamers directed patients to another service there were protocols in place to ensure that the appropriate information was shared.

Appropriate and safe use of medicines

- The system for the management and safe handling of medication was sometimes ineffective. A review of the emergency medication found the service did not hold or alternatively did not have a risk assessment in place to demonstrate the reasons for not holding the sufficient medicines for the types of medical emergencies which may present in this service. The provider explained that this was because some medicines were provided by the Trust. Following the inspection the provider immediately purchased the medicine and made it available for use in an emergency.
- The service had one ampoule of adrenaline stored in the resus trolley in a clinical room. Subsequently this was not immediately available to clinicians giving immunisations in other areas of the centre. It is recommended that adrenaline is held in the rooms where these immunisations are administered in response to the risk of an anaphylactic shock. Following the inspection, the service had purchased adrenaline for each room, a standard operating procedure and developed an anaphylaxis pack which all staff had been trained to use in its use.
- At the inspection we found the registered health professionals had failed to sign Patient Group Directions (Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). When we discussed this with the pharmacist, they said the PGDs were not yet active. We also found three members of the senior leadership team were unaware how medicines were administered when the clinician did not hold an approved prescribing qualification. We then discussed this with a member of the nursing staff, who said they obtained verbal approval from a doctor prior to administering medication, but this was not documented. We therefore found the system for legal authorisation to administer these medicines under a PGD, a PSD or via prescription was sometimes ineffective.
- Following the inspection, the provider explained that, to ensure staff competency they were in the process of rolling out a training programme and an assessment for staff so that they could use the PGD/PSD's. However, at the time of the inspection this was not in place. Following the inspection, the service implemented an audit of prescribing to ensure they are following the legal requirements fully.
- The service kept prescription computer stationery securely and monitored its use.
- Arrangements were in place to ensure medicines and medical gas cylinders were stored appropriately.
- The service had a lead pharmacist who had carried out audits for antibiotic prescribing and prescriptions of limited value in October 2019 and had shared this with staff in the January 2020 newsletter.

Track record on safety

- The provider leased the premises from the Trust. The management team told us that the Trust were responsible for premises and safety checks.

Are services safe?

- PELC had carried out their own calibration for small medical equipment used by the clinicians.
- PELC had commissioned an external company to complete their own premises assessment for the area they occupied at the hospital. This was completed on 28 March 2019. This audit identified several actions to be dealt with, mostly relating to producing documents, assessments, and evidence of checks and certificates which we were told were held by the Trust. We were advised that a copy of the premises assessment was sent by PELC to the Trust asking them for the necessary assurances and they were waiting for a response.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- Incidents and significant events were recorded on a computer software system that enabled the management team to oversee the investigations and actions taken.
- There were adequate systems for reviewing and investigating when things went wrong. We saw staff were part of an independent review and had carried out a route cause analysis where appropriate.
- The service learned and shared lessons, identified themes and took action to improve safety in the service. Learning from significant events was discussed at board level and information was cascaded to staff by a monthly 'safety matters' newsletter. For example, the most recently distributed 'safety matters' newsletter in February 2020 included that clinicians must not administer intravenous medicines in the Urgent Treatment Centre.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department.
- There was a system in place for the sharing of Central Alerting System (CAS) and Medicines and Healthcare products Regulatory alerts (MHRA). However, there was no system for assessing if non-medication alerts needed action. For example, there was no evidence that a recent alert regarding an AED defibrillator/cardiac monitor had been seen by an appropriate person or acted upo

Are services effective?

Effective needs assessment, care and treatment

When a patient walked in, self-referred, were referred by the NHS 111 service or assisted in a chair by the ambulance service to attend the urgent treatment service, their journey started at the streaming service. The streaming service was based in the entrance of the urgent treatment centre. Patients queued to be seen by the streaming staff who were located in pods in the waiting room. The purpose of streaming was to quickly determine the most appropriate place for a patient who walked through the front door to be assessed or treated. This included sending the patient to the right department within the hospital or redirecting them off-site to a more appropriate setting.

The service had agreements in place regarding the direction of patients to other services. The patients were given a colour coded card based on their needs and asked to report to the reception once the streaming process was complete, so that they could be booked into the relevant service. The colour coded card enabled the receptionists to know where to book the patient into. The main colour codes were: red for A&E majors, purple for majors 'lite', yellow for paediatrics A&E, blue for UTC minors' injuries and green for UTC minor illness. Dependent on the acuity of the patient they would be accompanied by staff or directed to the next service.

Patients directed to the UTC minor's injury and minor illness 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 within 30 minutes.

The streaming service was staffed by registered nurses who were grade six or above, advanced nurse practitioners, paramedics or emergency medical practitioners. The minor illness unit was staffed by GPs and the minor injuries unit by emergency medical practitioners and doctors.

The provider told us they followed 'Streaming and Redirection: The London Model'. The London Model recommends that there are clear protocols and software in place to assist with systematic streaming (appropriate protocols and software should be in place to assist the streamer in identifying the most appropriate disposition). However, we found the protocols in place did not provide the streamer with a consistent approach to aid the safe direction of patients.

The service's clinical streaming guidelines for staff to follow used diagnoses as the decision to send a patient to urgent treatment, accident emergency, refer back to the GP or refer to secondary care. Examples of the diagnoses were gastrointestinal bleeding, cardiac, frailty, fever, eye problems, collapse, and blood disorders. However, the clinical streaming guidelines did not fully demonstrate how the streamer should reach the diagnostic conclusion. The streaming guidelines did not include any specific common child illnesses such as croup or specific instructions for children.

A review of 15 patient records for children under the age of seven years found that the staff were not always following the guidance and completing observations prior to streaming patients to all areas. For example, there was an inconsistency in the taking of observations and in some cases no observations had been recorded. These included basic observations, pain score or assessment, early warning scores for children or reference to safeguarding concerns. The patient records sometimes lacked the necessary information to understand the streamers' decisions regarding direction.

Immediately following the inspection, the provider submitted information to demonstrate that they had introduced new streaming guidance regarding children. They also summitted an action plan that included reviewing all the streaming guidelines, ensuring adequate detail is given and recorded by streamers. In addition, they have amended the computer patient record system to ensure that staff have to complete and record basic observations during streaming. The provider also informed the CQC that they were to commence the auditing of patient records completed by streaming staff.

For the minor illness and minor injuries service, we found that patients' needs were assessed at the patient consultations and there was a system in place to ensure that the clinical staff were following current evidence-based practice.

Arrangements were in place to deal with patients who frequently attended the service. There was a system in place to identify frequent callers and patients with particular needs, for example patients with palliative care needs, and care plans were in place to provide the appropriate support.

Are services effective?

We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

- The service had completed 24 audits over a period of 18 months, two of the audits were two cycle audits: For example: -
- An audit of prescribing co-amoxiclav according to national and local guidance. The findings were shared with staff and a second audit evidenced a reduction in prescribing.
- An audit regarding community pneumonia looking at assessment and severity and safety netting advice. The second audit did not show any improvement in staff performance and a plan was implemented to improve this.
- The safeguarding lead had carried out an audit of the quality of safeguarding referrals.
- An audit of antibacterial prescribing in August 2019.
- An audit of prescriptions with limited clinical value in August 2019.
- The clinician's consultation notes were audited monthly to ensure compliance against national guidelines.
- A tramadol and opiate use audit in October 2019.
- The provider reported monthly to the local clinical commission group and the data was also shared with the Trust. This included the number of incidents, the number of safeguarding referrals, the response to friends and family tests, and the number and response to complaints.
- The service was meeting its locally agreed targets as set by its commissioner from 1 April 2019 to 31 December 2019. For example, they were meeting: -
- The operational standard that at least 95% of patients attending the UTC should be admitted, transferred or discharged within four hours. The time for all services started when the patients were seen by the streamers.
- The number of frequent attenders flagged to the patient's GP or CCG.
- The number of patients seen by the streamer within 15 minutes of arrival.
- The percentage of appropriate patients re-directed to other community and hospital-based services.
- Information of the number of patients referred to the different services such as A&E which had reduced the number of patients going to emergency department. This demonstrated an increased utilisation of the UTC of more than 70% in the previous nine months.

Effective staffing

The system to ensure all staff had the necessary training for their role was sometimes ineffective.

- Clinicians who worked in the minor illness and minor injuries and carried out patient consultations had an annual appraisal and monthly review of a percentage of their clinical notes. We saw that, where an issue was identified within a consultation, the lead clinician would provide feedback to the GP.
- On the first day of the inspection the provider was changing computer systems and did not have effective oversight of staff training to ensure all staff had completed the necessary training for their role. When we returned on the 12 February the human resource team had produced spreadsheets to monitor training.

However, we found:

- A significant proportion of the spreadsheets stated 'in progress' which we were told means either human resources were trying to obtain the certificate from the clinician/receptionist or via their agency, or the clinician/receptionist was in the process of completing the training. Following the inspection, the provider employed a human resource compliance officer, whose role was to ensure that all staff had completed the appropriate training for their role.
- We found the system to ensure the competency and performance of streamers, especially in regard to children under the age of five years, was sometimes ineffective. This was because:-
- On the first day of inspection we were told that the management team had introduced a new system of supervision for streaming staff in October 2019. Following the first day of our inspection, the provider submitted a flow chart to show how the service planned to implement the induction and oversight supervision. This showed that streamers would have clinical supervision monthly with a streaming lead and every three months with the head of clinical operations.
- However, when we asked for evidence, we were told by human resources that the clinical managers held some

of the supervision documents. The clinical managers provided documents and a list of staff who had completed one to one supervision sessions, but without the dates of completion; it therefore was difficult to establish which type was a monthly and which was a three-monthly supervision session. The clinical managers agreed the system required further embedding to ensure its effectiveness.

- We were told by the clinical managers that they would only review record keeping of streamer staff if the streaming data demonstrated an issue such as referring all children to the paediatric emergency department. Following the inspection, the provider has changed the patient record system to ensure streaming staff complete and record patient observations. In addition, the provider was planning to change the patients notes audit system to include streamers.
- On the first day the inspection, we found the streamer competencies did not include specific learning regarding children. Following the first day of inspection, the clinical management team introduced competencies specific to children.
- We reviewed the competency frameworks for eight streamers and three of these (dated 16 January 2019, 17 October 2018 and June/July 2019) were not fully completed or signed-off.
- Following the inspection, the provider submitted an action plan that included to further develop a performance management process for streamers, introduce a clinical audit system, improve training, review the competency framework, and include streamers in the clinical notes audit process.

Coordinating care and treatment

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

- Patients mostly 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 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.
- Issues with the Directory of Services were resolved in a timely manner.

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.
- 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 did not keep records of whether staff had completed any Mental Capacity Act or mental health training.

Are services 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.
- The service's NHS Friends and Family Test results demonstrated a mixed response to patient experience; from April to December 2019 an average of 52% of patients were satisfied with their care.
- The service's patient feedback found that, from November to December 2019, 73% of patients stated they were treated with dignity and respect.

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. Information leaflets were available in other languages to help patients be involved in decisions about their care.
- The service had a hearing loop for patients with a hearing impairment.
- The service's patient feedback found that, from November to December 2019, 51% of patients stated they were involved in decisions about their care.
- For patients with learning disabilities or complex social needs, the service involved their family, carers or social workers.
- 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 staff respected and promoted patients' privacy and dignity, however this was compromised by the layout of the premises. The premises were leased to the provider by the Barking, Havering and Redbridge University Hospital Trust. The provider informed us they were not allowed to make any changes to the premises without consent and had made various unsuccessful funding applications to change the reception area.

- The streaming areas located in the waiting room did not protect patients' privacy or promote dignity.
- The streaming pods did not have doors and other patients could hear the conversation in the waiting room. The provider had marked where patients should stand or sit away from this area, but this did not fully protect patients' privacy.
- The waiting room had 36 chairs and was unable to accommodate patients' relatives during busy periods.
- The restricted space limited patients' movements using mobility assistance equipment or for carers of children in pushchairs.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.

Are services responsive to people's needs?

Responding to and meeting people's needs

- The provider engaged with commissioners to secure improvements to services where these were identified.
- We found the waiting rooms had only 36 chairs, when these were full the provider had an escalation policy in place for staff to follow and had introduced the use of a children's and a minor injury waiting room. The escalation policy included asking relatives to stand for other patients in the waiting area.
- The urgent treatment centre offered step free access and all areas were accessible to patients with reduced mobility. However, the waiting area for the urgent care centre was not large enough to easily accommodate patients with wheelchairs and pushchairs if busy. Toilets were available for patients attending the service, including accessible facilities with baby changing equipment.
- Beverages were available in the main foyer of the hospital.
- The services website was not up to date. For example, the website stated PELC was responsible for the NHS 111 telephone and digital service, which was now the responsibility of London Ambulance service.

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 and found: -

- Patients were seen by the streamer on a first come first seen basis and directed to the most appropriate service. All patients had to be seen by the streamer within 15 minutes of entering the service. The minor injuries and minor illness units worked to a target of discharging a patient within four hours. The provider reported on these figures to the CCG monthly and was meeting the target of 95%.
- The service had agreements in place regarding the direction of patients to other services. The patients were given a colour coded card based on their needs and asked to report to the reception once the streaming process was complete, so that they could be booked into the relevant service. The colour coded card enabled the receptionists to know who to book the patient into. Minor injury and minor illness patients were then streamed into urgent and routine; those patients categorised as routine went back to the waiting room and waited for up to 4 hours, whilst urgent patients were seen within 30 minutes.
- Where patients were directed to paediatric and adult majors in the accident and emergency room, the staff accompanied patients to the department and provided the information at reception. We found both were a short walk away from the urgent care centre.
- For less urgent cases (called major 'lite'), patients were provided with a list of directions regarding how to find the reception. We made the journey to major 'lite' and found it was difficult to navigate with the instructions given and was not well signposted. We also noted the information was not available in other languages. This could potentially lead to delayed care and treatment. In addition, we did not see any information for patients explaining the streaming process and the colour coding.
- To ensure a prompt service the provider had two streamers on duty from 8am to midnight and one on duty from midnight to 8am, with a 'roving' streamer to observe and review patients in the waiting area from 8am to 8pm. Minor illness was staffed by GPs and had two working from 8am to midnight and one from midnight to 8am. Minor injuries was generally staffed during the day and evening by two emergency medical practitioners and a GP and one emergency medical practitioner from midnight to 8am.
- 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. We saw that over 8,000 patients attended the service each month. The age ranged from new-born babies to more than 75 years old. In December 2019 the service saw 402 children under the age of two years.
- 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 from the service within an appropriate timescale 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.

Are services responsive to people's needs?

- 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 complaints policy and procedures were in line with recognised guidance. From 1 February 2019 to 14 February 2020, the service had received 83 complaints, which had been received directly by the service or via the Barking, Havering and Redbridge University Hospital Trust. We reviewed two 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. In the February 2020 edition we saw lessons learned included the importance of clinicians documenting patient requests and improving documentation.
- 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. Staff provided a list of the main areas of learning in October and November 2019, which were regarding staff attitude, competent diagnoses, and receipt of informed consent.

Are services well-led?

Leadership capacity and capability

- During our inspection, the leadership team were responsive to our findings. Following the inspection, they submitted assurances that they had addressed the main areas of concern found on the inspection and submitted an improvement plan.
- 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.

Vision and strategy

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

- The provider had to retender for the service in 2019 and only found out the outcome of this process on 23 December 2019. This meant that they had had two plans in place; one for the closure of the services and one for growth. We were provided with the operational plan for 2019 to 2020.
- The service's vision was to create a health system that provided a patient focused and centred, culturally competent, clinically excellent and cost-effective care with exceptional outcomes and patient satisfaction.
- The service developed its vision, values and strategy jointly with external partners. The strategy was in line with health and social priorities across the regions it served. The provider planned the service to meet the needs of the local population.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The provider monitored progress against delivery of the strategy.
- The service had a corporate business plan in place for 2020 to 2025.

Culture

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with felt respected, supported and valued. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There was a strong emphasis on the safety and well-being of all staff.
- The provider had evidence that some staff had received equality and diversity training.
- 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 treatment services in England.
- The service shared significant events analyses routinely and were involved in round-table discussions with the Trust.

Governance arrangements

Leaders had not fully established systems, policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

- Partnership of East London Cooperative was a not-for-profit social enterprise delivering NHS integrated urgent treatment services (Clinical Assessment, GP Out of Hours and Urgent Treatment Centres), to more than two million people across East London and West Essex.
- The service governance was led by a chief executive who was supported by a senior leadership team that reported to PELC council. Local clinical and performance meetings fed into the integrated clinical governance committee, management executive team, finance, audit and remuneration meetings which in turn fed into the PELC council meetings (Board). We found the service held monthly integrated governance committee meetings.
- The protocols in place for the service did not provide the streamers with a consistent approach to follow, in order to aid the safe direction of patients. The provider had adopted protocols and procedures, but staff did not always adhere to them, for example 'Streaming and Redirection: The London Model' and the 'Clinical Streaming Urgent care/Treatment Centre' Policy.
- Immediately following the inspection, the provider submitted information to demonstrate that they had

introduced new streaming guidance regarding children. They also summitted an action plan that included reviewing all the streaming guidelines, ensuring adequate detail is given and recorded by streamers.

- At the time of the inspection, the management team did not have an accurate overview of staff recruitment. The system to ensure that all staff had the necessary training for their role was sometimes ineffective.
- Following the inspection, the provider employed a human resource compliance officer, whose role was to ensure that all staff had completed the appropriate training for their role and the recruitment system was effective.
- The provider had introduced a streaming competencies framework in 2018, however the management team had failed to ensure this system was adhered to. We found a new process for clinical supervision had been commenced for streaming staff but it was difficult to establish if staff had their clinical supervision sessions or one to one meetings because the process was not formalised or embedded.
- Following the inspection, the provider submitted an action plan that included to further develop a performance management process for streamers, improve training, and review the competency framework. The provider has changed the patient record system to ensure streaming staff complete and record patient observations. In addition, the provider was planning to change the patients notes audit system to include streamers record keeping.
- The management team did always have oversight of infection control arrangements, which were managed by the Trust
- The system for the management and safe handling of medication was sometimes ineffective. Following the inspection, the provider took immediate action to ensure an improved and effective system regarding medicines.
- The service had sought patient feedback but was not able to describe what actions they had taken in response to negative feedback.

Managing risks, issues and performance

- 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, prescribing and referral decisions.
- Leaders had oversight of incidents and complaints.
- Leaders had a good understanding of service performance against national and local key performance indicators.
- Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- The provider had an organisation risk register which included Queens Urgent Treatment Centre.
- The provider shared a bi-monthly integrated quality report with the local clinical commissioning group. This document included patient feedback, complaints, and safety issues.
- 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 for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- The information from incidents, complaints, patient feedback performance and safety alerts was shared with staff in the monthly bulletin and through mobile phone groups in order to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- 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.
- 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.

Are services well-led?

Engagement with patients, the public, staff and external partners

- The provider had developed standard operating procedures jointly with the Trust and staff told us they met with the Trust weekly to review progress.
- The provider attended a daily meeting where the pressure on the urgent care treatment centre and the emergency departments was discussed and responded to by both the Trust and the provider.
- The service involved patients, the public, staff and external partners to support high-quality sustainable services. The service had an electronic system which asked patients how likely they were to recommend the service and other questions relating to their experience of and satisfaction with the service. Patients could also write a comment. The results of this were shared with the local clinical commissioning group bi-monthly in the integrated quality report.
- The provider had included in the Quality Accounts for the financial year of 2018/19 that patients' feedback was to be monitored as an area for improvement. However, when we asked the management team about this, they were unable to provide any specific actions taken in response to low patient feedback results.
- The provider had carried out a staff survey in 2018, which included questions regarding the quality and safety of clinical practice and support from the management team. The majority of feedback was very positive and an improvement on the results of the staff survey in 2018.
- The provider informed both the Trust and the local clinical commissioning group about their performance monthly.
- Most of the staff working at Queens urgent treatment centre worked on a sessional basis, therefore information was shared through a monthly bulletin called 'safety matters'; this included any changes, complaints, incidents, feedback from patients, information about the service risk register, learning and reminders. In addition, the provider also shared non-confidential information through group text messages. We saw group meetings were held for permanent staff on 27 September, 2 December and 5 December 2019, which included reminders to staff about prioritising patients, including those aged under 5 years and about sepsis awareness.

Continuous improvement and innovation

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

- We found the leadership team and staff were focused on improving the service and responded immediately to the issues found at our inspection. In addition, they submitted an action plan in response to the inspection and prior to receipt of the inspection report.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The provider has increased the number of patients seen in the urgent treatment centre from 41% to over 70% since taking over the service, which resulted in less pressure on the A&E department.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is 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 **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • At the time of the inspection, the management team did not have an accurate overview of staff recruitment. • The protocols in place did not provide the streamer with a consistent approach to aid the safe direction of the patient. • The streaming staff were not always following the guidance provided and were not consistently completing observations prior to streaming patients to all areas. • The system for the management and safe handling of medicines was sometimes ineffective. • The management team did not always have effective oversight of infection control arrangements. **These matters are 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 **The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and to improve the quality and safety of the services being provided. In particular:**

This section is primarily information for the provider

Requirement notices

- Leaders had not fully established systems, policies, procedures and activities to ensure safety and assure themselves that they were operating as intended.
- The system to ensure all staff had the necessary training for their role was ineffective.
- The provider had introduced a streaming competencies framework in 2018, however the management team had failed to ensure this system was adhered to.
- We found a new process for clinical supervision had been commenced but it was difficult to establish if staff had had their clinical supervision sessions or one to one meetings because the process was not formalised or embedded.
- We were not provided with any evidence of how the provider had responded to negative patient feedback results.

These matters are in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014