Croydon Urgent Care Centre

Quality Report

530 London Road
Thornton Heath
Croydon
CR7 7YE
Tel: 020 8401 3013
Website: virgin**care**.co.uk/vc-providers/south-**croydon**-**urgent**-**care**-**centre**

Date of inspection visit: 17 June 2015
Date of publication: 12/11/2015

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 service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Croydon Urgent Care Centre on 17 June 2015. Overall the practice is rated requires improvement.

Specifically, we found the service to require improvement for providing safe, effective and well led services. It was good for providing caring and responsive services. The provider operates an out of hours service from the same location which was not inspected during this visit.

Our key findings were as follows:

- Patients said they were treated with respect and did not raise concerns regarding privacy. However the reception and waiting area is open so conversations can be overheard and while treatment rooms have curtains, they provide minimal privacy;
- Patients were generally happy with the care and treatment they received, although they were not always satisfied with the time they had to wait to receive treatment;
- Information about how to make a complaint was available to patients and suitable arrangements were in place to deal with complaints;
- The provider and the centre had systems in place to seek feedback from patients about the services it provided;
- The urgent care centre is open 24 hours a day 365 days a year and accessible to all who attended;
- Staff understood their responsibility to raise concerns and report incidents, although there were limited opportunities for meetings to discuss learning;
- While audits had been carried out there was not a completed cycle and they did not demonstrate improvements made;
- The service had developed a range of policies and procedures to govern activity, although some staff reported they did not have good access to them;
- Staff recruitment practices were generally in line with requirements;
- New staff received an induction to ensure they had the information they needed to carry out their role;
- Systems were in place for staff to receive annual appraisals.

Summary of findings

There were areas of service where the provider needs to make improvements.

Importantly, the provider must:

- Ensure the process for reporting and recording incidents is improved so the system is accessible to all staff and that lessons learnt are discussed and shared with relevant staff;
- Ensure GPs are trained to the required Level in child protection;
- Ensure a record is maintained of the fridge temperatures on a daily basis;
- Ensure the details of any cancelled prescriptions are recorded in line with the provider's policy and guidance;
- Ensure there are clear and effective systems in place to assess, monitor, mitigate risks and improve the quality and safety of the service through the completion of clinical audit cycles, learning from incidents and complaints and engaging with staff.

In addition the provider should:

- Look at ways to improve privacy for patients, at reception and in treatment areas;
- Ensure staff record checks made of clinical trolleys and any actions required or taken;
- Be able to assure themselves that those tasks being carried out by hospital trust staff are being done to the appropriate standard. This included cleaning of communal areas and testing of electronic equipment;
- Continue to recruit to vacant staff posts to reduce the reliance on locum staff;
- Consider providing specific training for staff relevant to working in an urgent care centre.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The service is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibility to raise concerns and report incidents, however they experienced issues with the combination of paper and electronic records and had limited opportunities to discuss any lessons learnt. We found that staff would not report a missed fracture as a significant event, which was not in line with the provider's policy. Safeguarding policies and procedures were in place and while staff had completed training in child protection, GPs had not completed it to the required Level. Audits of children's records identified the safeguarding sections were not always completed in full. Suitable recruitment policies and procedures were in place. Arrangements for storage and ordering of medicines were appropriate. Records were taken of the medicines fridge. Although records prior to May 2015 were not available, we were told that this was due to a system change. Prescription voids were not being recorded as per the provider's policy. Actions from an infection control audit were being worked through. Schedules were in place for testing and servicing equipment, although some items had not been included. The service did not have equipment to deal with medical emergencies as patients were referred to the co-located emergency department, if necessary.

Are services effective?

Requires improvement

The service is rated as requires improvement for providing effective services as there were areas it should make improvements.

The service is rated requires improvement for providing effective services as there were areas it should make improvements.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff referred to guidance from the National Institute for Health and Care Excellence. Systems were in place for patients to be referred to other health care providers when required. While audits had been completed, they did not demonstrate improvements made. Staff had access to training, although those we spoke with said they had not completed anything specific regarding working in an urgent care centre. The provider had systems in place for staff to receive annual appraisals.

Are services caring?

Good

The service is rated as good for providing caring services.

Summary of findings

Patients views gathered during the inspection visit indicated that they were treated with respect and dignity. We also saw staff spoke with patients in kind, caring and responsive ways. While the reception and waiting area and treatment areas continued to not be conducive to maintaining patient's privacy, the provider and the Clinical Commissioning Group (CCG) told us about the plans for a new development which would address these issues.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

Staff demonstrated a good knowledge of the local and wider population and engaged with the CCG to make improvements to the service. Services were planned to take into account the needs of the population likely to attend the centre. The service was accessible for people who used a wheelchair, mobility aids and parents and carers with pushchairs. The service had access to translation services when required. Information about how to make a complaint was available on the provider's website and in the waiting area. However, there was a lack of evidence to show the provider was learning from complaints.

Are services well-led?

Requires improvement

The service is rated as requires improvement for providing well led services as there are areas where it must make improvements.

The service had clear vision and values. Staff were clear about their role and responsibilities. There was a clear leadership structure. The service had a range of policies and procedures to govern activity. There were some systems in place to identify and monitor risk, but the provider was unable to demonstrate how it monitored the quality and made improvements to the service. There was no evidence of improvements being made following clinical audits, there was limited evidence of sharing learning from complaints and or significant events with relevant staff and staff meetings were not taking place. The centre sought feedback from patients and was looking at how they could improve the level of feedback received from patients and how best to communicate with staff. New staff received an induction and systems were in place for staff to receive an annual appraisal.

Summary of findings

What people who use the service say

We spoke with twelve patients during our inspection visit and received comment cards from six patients who visited the urgent care centre during the two weeks before our visit.

Patient feedback indicated that they felt staff were friendly and polite. Half of the people we spoke with and who submitted comment cards were not satisfied with the length of time they had to wait to be seen. This ranged from one to three hours on the day of our inspection. The waiting time for emergency departments and urgent care centres is four hours.

Not all patients we spoke with were clear about the difference between the urgent care centre and the emergency department, although this was not really an issue to them.

The service had used various systems to seek patients feedback about the services provided over the last year and was currently using the Friends and Family Test. The number of responses received had been relatively low with 86 responses received so far this year. The issues patients had raised were around waiting times. The centre had reviewed staff performance and staff levels in response to this.

Areas for improvement

Action the service MUST take to improve

- Ensure the process for reporting and recording incidents is improved so the system is accessible to all staff and that lessons learnt are discussed and shared with relevant staff;
- Ensure GPs are trained to the required Level in child protection;
- Ensure a record is maintained of the fridge temperatures on a daily basis;
- Ensure the details of any cancelled prescriptions are recorded in line with the provider's policy and guidance;
- Ensure there are clear and effective systems in place to assess, monitor, mitigate risks and improve the quality and safety of the service through the completion of clinical audit cycles, learning from incidents and complaints and engaging with staff.

Action the service SHOULD take to improve

- Look at ways to improve privacy for patients, at reception and in treatment areas;
- Ensure staff record checks made of clinical trolleys and any actions required or taken;
- Be able to assure themselves that those tasks being carried out by hospital trust staff are being done to the appropriate standard. This included cleaning of communal areas and testing of electronic equipment;
- Continue to recruit to vacant staff posts to reduce the reliance on locum staff;
- Consider providing specific training for staff relevant to working in an urgent care centre.

Croydon Urgent Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP and a practice manager specialist advisor, an Expert by Experience and two CQC inspectors. The specialist advisors and Expert by Experience were granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Croydon Urgent Care Centre

Croydon Urgent Care Centre provides a service for the treatment of minor to moderate illnesses or injuries which do not require treatment in the emergency department. The centre is led by seven GPs with a staff grade doctor, seven emergency nurse practitioners, three staff nurses, two health care assistants, 13 reception and four managerial staff. At the time of our inspection, there were eight vacant positions at the centre. The service is available to all people with an urgent health need 24 hours a day 365 days a year. They see approximately 4,000 patients each month. The service is provided by Virgin Care Wandle LLP on behalf of the Croydon Clinical Commissioning Group. Virgin Care LLP is a subsidiary of Virgin Care which operates a large number of health and social care services across the country. The provider operates the urgent care centre and the GP out of hours service from the one location, they are registered to provide the regulated activities of diagnostics and screening procedures, treatment of disease, disorder or injury, surgical procedures and for the out of hours service transport services, triage and medical advice provided remotely. This inspection focused on the urgent care centre. The Urgent Care Centre is situated in the emergency department at Croydon University Hospital and all patients for both services are seen initially by reception staff working at the urgent care centre.

We inspected the service for the first time in February 2013; the five outcomes inspected were compliant. A further inspection was carried out in July 2013; this identified three issues where the service was not meeting the essential standards of quality and safety. Patients were not treated with consideration and given information and support about their treatment; patient's health and safety was not protected and patient's privacy and dignity was not maintained. We also found the streaming for patients on arrival at the centre was carried out by non-clinical staff. Compliance actions were made and the provider sent an action plan detailing the improvements they would make to become compliant.

We carried out a responsive inspection in September 2013 following concerns raised during the inspection of Croydon University Hospital earlier the same month. This inspection identified continued concerns regarding patient privacy not being maintained and there had been no changes to the streaming of patients when they initially attended the centre.

We carried out a follow up inspection in July 2014 to check the progress the provider had made with meeting the Regulations and found improvements had been made, although there were still issues with patient's privacy not being maintained. There had been the addition of a Vital Early Warning Score (ViEWS) assessment (completed by a health care assistant) to the streaming of patients when they initially attended the centre. We made a compliance action regarding the design and layout of the building not adequately protecting patient's privacy and dignity.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme for out-of-hours emergency cover for GP services.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We met with the Clinical Commissioning Group. We reviewed the Healthwatch report from a visit in March 2014.

While a set of London Quality Standards was produced in February 2013 we were told by the CCG that these were not being used to measure performance of urgent care centres at this time.

We carried out an announced visit on 17 June 2015. During our visit we spoke with 12 patients and a range of staff including three GPs, one nurse, one healthcare assistant, two reception staff and four managers. We observed staff interactions with patients in the reception area. We looked at the provider's policies and records including, staff recruitment and training files, health and safety, building and equipment maintenance, infection control, complaints, significant events, clinical audits and a sample of patient records. We looked at how medicines were recorded and stored. We reviewed comment cards where patients shared their views and experiences of the service. We asked the provider to send us some information about the service before our inspection.

Requires improvement

Are services safe?

Our findings

Safe track record

The service used a range of information to identify risks and improve patient safety. For example, national patient safety alerts were disseminated to relevant staff, although there was no system to ensure they had been read and acted upon. Staff we spoke with were aware of their responsibility to raise concerns and knew the process to be followed. There was a system in place for reporting and recording significant events. We saw the provider's policies regarding incidents, accidents and significant events; these were included in the induction for new and locum staff. We were told reporting system was a mix of electronic and paper records and clinical staff continued to experience issues with accessing the electronic system. Clinical staff had difficulty showing us completed incident forms during our visit, but we did receive copies of significant events as part of the pre-inspection request from the provider. We discussed with the clinical lead what constituted a significant event and were given an example which indicated that a missed fracture would not be recorded as a significant event. This was not in line with the provider's incident policy.

Learning and improvement from safety incidents

The provider had systems in place to share learning from significant events across the whole organisation. This was in the form of clinical practice updates being sent to staff and information about significant events being made available to staff at the providers services. Following a significant event, the provider had developed a Standard Operating Procedure for patients presenting to the urgent care centre more than once with the same condition. This procedure gave staff clear guidelines to follow. Clinical staff we spoke with were aware of the two most recent events from newsletters sent out by the provider but said they did not have opportunities to formally discuss learning points with colleagues. We were told the last clinical meeting had been towards the end of 2014, so there had been no recent opportunities for staff to discuss lessons learnt from significant events.

Reliable safety systems and processes including safeguarding

The service had clear policies and procedures for staff to follow regarding child protection and adult safeguarding. The contact details for the local authority safeguarding and child protection services were displayed and available for staff. The clinical lead was the safeguarding lead for the service. Staff we spoke with were clear about their responsibility to report safeguarding and child protection issues and were aware who the safeguarding lead was for the centre. A safeguarding audit of children's records had been carried out on 25 records between January and May 2015. The audit identified clinical staff were not routinely completing the safeguarding box and there were gaps in other parts of the records. The audit noted the findings were to be reported to the individual clinicians concerned, although there was no evidence that this had been completed. Clinical staff told us they had not discussed safeguarding concerns as a group.

The service had not made any child protection referrals, staff told us this was because children were triaged by staff within the emergency department where safeguarding concerns would be identified. The clinical lead had recently met with the CCG and the hospital trust to discuss safeguarding and confirm the processes in place within the centre.

Reception staff had completed training in child protection to Level 2. Clinical staff were trained to Level 2 with two of GPs at Level 3 and one at Level 2.

There was a chaperone policy which made it clear that staff needed to offer patients a chaperone before they carried out any intimate examinations and that only staff who had completed training in chaperoning and had a Disclosure and Barring Service check would be asked to carry out this task. The chaperone policy was displayed in the treatment rooms. We saw a record of reception staff who had carried out chaperone training and would be available to act as chaperone if required.

Medicines management

Records showed weekly checks were completed of medicines with suitable arrangements for ordering when stocks were getting low. Medicines in stock were within their use by date. There were three clinical trolleys. Staff told us these were checked daily although records were not kept of these checks. We saw a first aid box in one of the offices; no checks were made on the contents, although we were told this was only for staff use. Clinical staff told us

they completed training in medicines management and they had signed the Standard Operating Procedure for Medicines Management which indicated how to store and record medicines and how to keep prescriptions safe.

Records showed fridge temperatures were taken daily except for two days in June. However there were no records available before May 2015. There was no back up thermometer for staff should the fridge thermometer fail. The temperature of the cupboards where medicines were stored were checked daily with the exception of one day in June 2015.

We saw prescription pads were stored securely. Staff kept a record of serial numbers of prescriptions issued. There were three prescriptions that had not been voided as per the provider's policy. We were told that a new protocol was to be put in place in the near future.

GPs had access to the hospital trust intranet for guidance about prescribing medicines including antibiotics.

Cleanliness and infection control

We observed the waiting area and treatment rooms to be clean and tidy. Patients commented they found the place to be clean and had no concerns. The service had policies and protocols regarding infection control. We were told that cleaning was carried out by the hospital trust. There was no cleaning checklist and no evidence that the provider carried out routine checks of the cleaning to assure itself the required standards were being met. The health care assistant described the routine cleaning they carried out in the initial assessment room on a daily basis. This cleaning included the examination table, desk, chair, computer and checking the sharps bin was below the fill line.

The manager was the infection control lead. An infection control audit was carried out in May 2015 using a standard tool. This indicated a number of areas to be addressed including: displaying posters for staff; checking contact details for infection prevention control advice; adding infection control to the staff induction booklet and developing procedures for handling specimens. Staff told us they were working through an action plan and would be carrying out a further audit in the near future to check all the improvements had been made. We saw posters regarding hand washing were displayed for staff in clinical areas and for patients in toilets. The induction handbook for clinical staff dated June 2015 had not been updated to include information about infection control. Previous audits were not available so we were not able to see if there were previous issues and if they were addressed; we were told this was due to recent changes in staff responsible for this role. Staff files we saw did not include records to confirm they had completed training in infection control. Staff we spoke with told us they had received training in infection control.

A legionella risk assessment had been completed and hospital staff carried out the required checks on water temperatures. (Legionella is a bacterium which can contaminate water systems in buildings).

Equipment

Staff told us they had access to equipment they needed. Systems were in place for equipment to be calibrated annually, records indicated this was carried out in December 2014.

Staff told us portable electrical appliance testing (PAT) was carried out by the hospital trust and the service did not have copies of the last test. Staff told us that electrical appliances were tested in April 2013, although not all items we saw had a pass sticker on. In clinical areas the PAT stickers indicated they were due for testing in December 2015. There was no evidence to show the provider was assured these checks were carried out in a timely manner. The fire alarm system and fire extinguishers were checked and serviced regularly, the hospital trust kept copies of the checks which the service could access when required. A fire risk assessment had been completed by the hospital trust.

Staffing and recruitment

The policy and process for staff recruitment included prospective candidates submitting an application, attending an interview and references and checks being completed before new staff started work. The process included checking clinical staff registration with the relevant body.

We reviewed three staff files and saw they included proof of the individual's identity, confirmation of their registration with the General Medical Council or the Nursing and Midwifery Council, their Hepatitis status, their qualifications and a recent Disclosure and Barring Service check.

We received information before the inspection alleging there were not enough staff working at the service for it to operate safely. We were told by staff at the service and the

Requires improvement

Are services safe?

CCG that the service had been using high numbers of agency and locum staff during April and May 2015 and that some individual staff had not turned up for work giving the service very little notice to get cover. The managers told us they had recruited some new clinical staff and their dependence on locum and agency staff had reduced. Staff we spoke with felt there were generally enough staff and told us about the arrangements to use locum and agency staff to cover vacant positions, staff holiday, sickness and training. The service had developed an action plan which covered staff recruitment, increasing the number of locum agencies to be used and support for clinical staff to increase the number of patients seen on an hourly basis.

The GP establishment for the service was for almost seven whole time equivalents, but only three full time GPs were employed at the time of inspection. The three staff nurse positions were filled. Two emergency nurse practitioner posts had been recruited to and start dates set for the beginning of July 2015, this left a 40% vacancy rate with two staff on long term sick leave. There were 10 whole time equivalent reception staff in post with three vacancies. The provider was attempting to recruit to the vacant posts.

We looked at the staff rota for three weeks, one in February, one in April and the week of our inspection. These showed there was one GP working in the morning, afternoon and overnight, one staff nurse worked from 8am-5pm five days a week with an extra nine hour shift three days a week, three emergency nurse practitioners worked during the day. One healthcare assistant worked during the day and another through the night so this position was covered throughout each 24 hour period, which was in line with the requirements and with the centre's staffing policy. We were told about the escalation processes when there was a breach, for example when patients went over the 20 minute timescale for the initial health check and the four hour wait to be seen, treated and discharged. The CCG monitored the service on a daily basis and was informed when the service was becoming busy and breaches were happening. The managers told us about plans to initiate a 'white board system' where they could see at a glance the number of patients who needed the initial assessment, the number who were waiting for treatment or for referral to other services and those ready for discharge, to help manage the service.

The initial observation of patients carried out by a health care assistant should be carried out within 20 minutes of a patient attending the centre. Records showed that the centre had consistently failed to meet this target (95%) every month for the past fourteen months. We saw it achieved between 81-90% of patients being assessed within 20 minutes each month during the last fourteen months. This initial assessment was carried out by one health care assistant on each shift. This could impact on patients being referred on to the emergency department pathway and receiving care when they need it. The provider was aware of these breaches and had put an action plan in place to recruit staff to vacant posts. They had an escalation policy in place to monitor the number of patients waiting to be seen with systems to call upon extra staff if required. This policy included informing the CCG in addition to the regular monitoring telephone calls they had on a daily basis. According to the emergency department, in April and May 2015 up to 10 patients a day were incorrectly sent to the urgent care centre. However this data was not formally collected by the centre.

Monitoring safety and responding to risk

The service had systems and policies in place to manage and monitor risks to patients, staff and visitors. Health and safety risk assessments were completed; the service had a lone working policy and policies for staff regarding dealing with difficult behaviour. Reception staff confirmed the systems in place to protect staff and other patients. There were a number of flow charts displayed in reception to show staff how to stream patients. Information about how to respond to a range of events was displayed in reception to help staff deal with different situations.

Arrangements to deal with emergencies and major incidents

Emergency medicines and equipment to deal with a range of medical emergencies including oxygen and a defibrillator were not held in the centre, staff told us that medical emergencies were dealt with by the emergency department, which it shared facilities with.

The centre had a business continuity plan which was developed in conjunction with the hospital trust. This document detailed how staff should respond to a number of events including a power cut, flood or fire. We were given examples of when this plan had been put into place and

Requires improvement

Are services safe?

the information included had given staff the details they needed. There was also an escalation policy regarding actions to take if clinical staff did not attend for work at short notice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence and local commissioners. We saw guidance from commissioners was available to staff on the electronic recording system. Clinical staff told us they used the local Clinical Commissioning Group (CCG) guidelines for prescribing.

The centre used a combination of paper and electronic records. Clinical staff told us this presented them with some issues, but not to the recording of any advice and treatment given. We were told about the imminent plans for improvement to the electronic recording system which would alleviate current issues.

On arrival at the urgent care centre patients were streamed by non-clinical reception staff to either be seen by staff at the urgent care centre or the emergency department. At this point reception staff told patients the approximate waiting time. Reception staff received training in how to carry out streaming and had competency assessments to ensure they were doing the assessments correctly. Children were sent directly to the paediatric emergency department to be triaged by one of the paediatric nurses. Once assessed, children may be directed to see staff at the urgent care centre; staff told us around 70% of children were seen by urgent care staff.

After this initial streaming, patients were given a colour coded information sheet, describing what they should expect. Clinicians used a 'see and treat' pathway, which included taking a more detailed medical history, investigations, diagnosis, care plan, treatment and discharge.

A healthcare assistant carried out initial observations which included taking a patients pulse, temperature, blood pressure, heart rate, respiration rate, oxygen level and record their responsiveness level. This assessment gave a patient a clinical score, which informed staff if the patient was to remain in the UCC or be moved to the emergency department pathway.

Clinical staff confirmed they had access to telephone interpreting services when required.

Management, monitoring and improving outcomes for people

The clinical lead carried out at least a 1% audit of all records each month and this equated to 40 – 50 clinical records for the service each month. Although these audits were not made available to us during the inspection.

The clinical lead told us that the service carried out audits on rolling monthly programme. We saw audits on head injuries, ankle injuries and asthma. However, none of these had gone through a full audit cycle and were able to demonstrate improvements made as a result.

One of the nurses had carried out an audit on urinary tract infections and ankle injuries. The audit on ankle injuries had included a review of 50 patient records detailing the assessments completed and whether they had included the checks required to rule out fractures. The audit identified six sets of patient notes where the clinician had not completed these checks. The audit noted feedback would be given to clinicians and a repeat audit completed, although timescales for these actions were not specified. The audit on urinary tract infections was carried out on 16 patient records. Recommendations from this audit indicated further discussion with clinical staff was required regarding their rationale and need for urinalysis testing. The audit was to be shared with clinical staff and where individual staff had not completed the patient's medical history as required, they were to receive additional feedback. There was no evidence to demonstrate these actions had been completed.

One of the GPs had carried out an audit on patients presenting with headaches in May 2014. The overall conclusion was that patient notes were sufficient and there were no concerns regarding patient safety. The findings of this audit were recorded as having been shared with available clinicians and a suggestion for a training session on the NICE guidelines for headaches and a repeat audit to be carried out three months later. There was no evidence that a further audit had been completed. GPs we spoke with had not carried out audits.

We were told the service had experienced difficulties auditing patient waiting times and the number of patients who transferred to the emergency department after they

Requires improvement

Are services effective?

(for example, treatment is effective)

were seen by a GP or emergency nurse practitioner at the centre due to issues with the computer system. The CCG shared details of waiting times with us before the inspection.

There was no system to audit patients attending due to experiencing difficulties getting an appointment seeing their own GP which is one of the London Quality Standards for Urgent Care.

Effective staffing

Centre staffing included, medical, nursing, reception, administrative and managerial staff. The provider had arrangements for staff to receive regular training and updates. However we were told by staff that this did not include anything specific for staff working in the urgent care centre environment. The provider had plans to develop a bespoke training programme for staff working in their urgent care centres. The clinical lead told us they gave talks to staff about interpreting X-rays, however staff we spoke with had not attended one of these talks. Clinical staff described their induction which included electronic learning regarding fire safety, infection control and basic life support. We saw the training matrix which identified training staff had completed and when refresher training was required. We were not able to view training certificates during our visit, as these were not kept in staff files.

We saw records of dates reception staff and nurses had their annual appraisal. GPs we spoke with told us they had annual appraisals and were preparing for their revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). The service did not have a system to record the dates of GPs appraisals.

The provider had policies and procedures to respond to issues relating to staff performance. The manager gave an example to describe how this worked.

Working with colleagues and other services

Protocols and arrangements were in place for patients to be referred to the hospital trust or other local hospitals depending on their clinical needs. GPs we spoke with confirmed that patients would be advised to see their own GP and were given a copy of their discharge summary to discuss any concerns not addressed during their visit. There were systems in place for staff to refer patients to other health care services when appropriate.

The centre was located within the emergency department of Croydon University Hospital. There were different recording systems used across the hospital trust and within the urgent care centre with patients being registered on one computer system and treatment being recorded on another computer system. Staff told us this presented them with some issues, although they were working to improve this.

Information sharing

Clinical staff told us they did not attend multidisciplinary meetings, although they did not give reasons for this. Letters to patients own GP were emailed or faxed to the practice by reception staff.

Consent to care and treatment

We reviewed some patient records which indicated consent to examination and treatment had been discussed or implied and clinical staff told us when they were sending letter to patients own GP, they asked the patients permission. We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. Clinical staff we spoke with understood the legislation and described how they implemented it by assessing patient's ability to make decisions. Clinical staff demonstrated they understood the Gillick competency test. (These are used to assess whether children under the age of 16 are mature enough to make their own decisions and to understand the implications of their decision).

Health promotion and prevention

Staff demonstrated a good knowledge of the health needs of the local and wider patient groups who may attend the centre. There were some relevant health leaflets and posters displayed around the centre. GPs told us they offered patients general health advice within the consultation and if required they referred patients to their own GP for further information.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw reception staff greeted and welcomed patients appropriately. They spoke politely, explained the process and approximate waiting times. All of the comment cards we received indicated that patients were happy with the way they were spoken to. Patients told us staff were friendly, welcoming and polite.

Whilst the reception was open, patients we spoke with did not raise issues about their privacy being compromised. The provider has policies for staff regarding privacy, dignity and confidentiality. Consultations were carried out in cubicles which had fabric curtains; however, the design and layout of the treatment areas did not afford patients privacy. The provider was aware of this and informed us of the plans to redevelop the service from November 2015.

The provider had used a range of surveys to seek feedback from patients in the past and had received low numbers of responses compared to the number of patients attending the service. Throughout June, July, August and September 2014 most comments received from patients were positive with the exception of the time they had waited to be seen. Although we saw the waiting times had been within four hours for the majority of patients. From February 2015 the centre had started to use the Friends and Family Test and had received 86 comments, of which the only concerns raised were around waiting times. The service had reviewed the times patients spent in the centre and was working through an action plan which included recruiting new staff and improving the time clinical staff took to see patients and discharge them. The centre was looking at how to improve the number of responses received from patients because this remained well below the number of patients who attended the service.

Care planning and involvement in decisions about care and treatment

There were clear signs to show the services at the urgent care centre were provided by a different organisation to the hospital, patients we spoke with were not always clear about the difference, although this was not really an issue to them, until they needed to make a complaint.

There was information about the urgent care centre and service provided on the providers website with some information displayed in the waiting area. There were some information posters displayed around the waiting area, although staff reported that they generally kept leaflets behind reception, which meant patients needed to ask for them.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with who had received treatment reported that they were satisfied with the treatment they received. There were a range of posters in the waiting room about local health and social care services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the urgent care centre (UCC) was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the local population were understood and systems were in place to address identified needs in the way services were delivered. One of the management team demonstrated their knowledge of the local area in terms of its demographics and key health statistics. They were aware of how this impacted on the service provided, for example, in terms of the types of issues which patients presented with at the centre.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them to discuss local needs and service improvements that needed to be prioritised. This included regular meetings to review performance including financial and clinical elements of the service. However, multidisciplinary working with the emergency department was inconsistent, we saw that the manager attended 7 out of 13 meetings between March and June 2013.

The service received feedback from patients via the 'Friends and Family' test, NHS choices, complaints and general comments reported to reception staff. Patients reported through 'you said, we did' that the waiting room was too hot in March 2015. Staff at the centre reported this to the hospital. In April 2015 patients comments indicated they waited too long to be seen, the centre responded by putting additional staff on at key times over the weekend. In May 2015 patients requested that waiting times were displayed. The centre was looking at how this could be achieved.

The service were aware of local events that might impact the number of attendances, an example of this were local cycling events, staff told us how they worked with other local organisations to ensure staff were able to get to work during road closures and diversions.

Tackling inequity and promoting equality

The centre had recognised the needs of different groups in the planning of its services. There were established protocols which had been developed with the co-located emergency department regarding the treatment of people with learning disabilities, dementia or mental health issues. For example, those experiencing obvious mental health issues were directly referred to a psychiatric service for treatment. Patients with dementia who presented at the UCC were streamed towards the emergency department which had a specialist 'dementia zone' where appropriate support could be given. There were also specially trained nurses working at the hospital who were available to provide support to people with learning disabilities.

The centre is located in a culturally diverse area. Information in the waiting area was displayed in a range of languages. If people could not communicate with reception staff in English then they were asked to self-identify their preferred language using a printed translation leaflet. Reception staff could then request assistance from other staff and clinicians at the hospital who spoke in the relevant language. They also had access to a telephone translation service, if required.

The premises and services had been designed to meet the needs of people with disabilities. The centre was accessible to patients with mobility difficulties and facilities were all on one level. There was one low counter and window at reception to ensure people using a wheelchair could speak to staff when they arrived. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the service easier and helped to maintain patients' independence. However, there were times during the day when the waiting room was very full with some patients standing while they were waiting to be seen.

Staff told us that some patients had "no fixed abode" and these were seen and treated in the same way as any other patient. They were welcomed at the UCC and supported to receive all the care and support needed on the day. There was a hearing loop installed on the premises to support those who were hard of hearing and large print information materials were provided to those with some visual impairment.

There were currently only male GPs working at the centre, but the majority of nurses were female; therefore patients could choose to see a male or female clinician. Patients could request chaperone support if they were not comfortable being examined on their own with any one clinician. Information about chaperoning services were displayed in each of the treatment cubicles.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The service provided staff with equality and diversity training and this topic formed part of new staff members induction programme. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff meetings and appraisals.

Access to the service

The UCC was open 24 hours a day, seven days a week. Approximately 4,000 patients were seen by the service each month. Comprehensive information was available to patients about access on the centre's website and information was also displayed in the waiting area.

Patients arrived at the emergency department at Croydon University Hospital and were then streamed by reception staff to attend either the UCC or the emergency department. Patients with minor injuries and illness were seen by the UCC; those with life-threatening conditions were sent straight to the emergency department. Patients were generally seen on a first come first served basis, but there was flexibility in the system so that more serious cases could be prioritised as they arrived. All children were prioritised and directed through to the emergency department to be assessed by a paediatric nurse and could be referred back to the UCC for treatment.

Patients we spoke with were generally not satisfied with the length of time they waited to be seen. We reviewed the data the UCC kept on time to treatment for patients. We found that the centre had consistently exceeded the target set of 95% of patients being treated and discharged within a time frame of four hours every month over the past year. There were some notable breaches of this target at the end of March and throughout April 2015 with only 94.7% of patients being seen and discharged within four hours. The target changed in April to 98% which was achieved in May 2015. We discussed this with the management team. They had instigated a new staff rota around this time and found that this had led to some problems. We also saw that a number of clinical staff had either left or been off during this time. Additional clinical staff resource had subsequently been allocated by the CCG to help rectify the problem. The provider had developed an action plan to ensure improvements were made.

There were protocols in place to monitor the flow of patients with a view to minimising waiting times. For example, nurses were instructed to start triage of patients if more than five patients were waiting to be assessed by the health care assistant at any one time. There was also an escalation protocol if waiting times were increasing; this included the use of a telephone triage with a trained nurse.

One of the managers demonstrated the system for analysing waiting times and any breaches of waiting time targets. They showed us an example from one day in June 2015 where a GP had been unable to attend at the scheduled time. They tracked the impact of this delay and identified what could have been done throughout the day to lessen the impact of this staff member's absence.

The management team were working towards improving the waiting times and had spent time analysing waiting time data. They were in the process of implementing a new shift leader position. The leader would hold responsibility for managing the flow of patients throughout the day using a new 'whiteboard' alert system. They had also identified their peak times which had led to a review of shift patterns; they were now considering changing the allocation of resource to reflect the greater demand later in the day and earlier in the morning.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance. There was a designated responsible person who handled all complaints at the centre. The clinical lead investigated any clinical complaints and the office manager investigated customer satisfaction complaints and concerns. They were supported by a central customer services department run by the provider. We looked at a sample of the twenty seven complaints received in the last year, twenty of which were relating to clinical care and treatment received. We saw all complaints had been responded to and records indicated the actions to be taken by staff within the service. It was not clear how learning from complaints was shared across the service. Where clinical complaints had been investigated and areas for development were identified, these were noted to be presented at governance meetings. Not all clinical staff were able to attend the governance meetings. We were told that the information was available to the team, although staff we spoke with were not all aware of the outcome and learning from investigations of clinical complaints.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. This included a noticeboard about complaints handling in the waiting area which directed people to approach the reception desk with concerns in the first instance. There were leaflets about how to make a complaint and information about the Patient Advice and Liaison Service (PALS) available from the reception staff. None of the patients we spoke with had ever needed to make a complaint about the service.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The provider had a clear vision to provide patients in Croydon with high quality, easy and convenient access to GPs and nurses when needed. All staff we spoke with were clear about the purpose of the service and the providers values. We were told that staff across the organisation had been involved in developing the values.

Governance arrangements

The provider had developed the required policies and procedures for staff, although a number of staff we spoke with were not able to access them easily and referred to them 'being in the office'.

There was a clear leadership structure and named staff in lead roles, for example a clinical lead who oversaw the operation of the centre and was the safeguarding lead and an infection control lead. With the exception of the clinical lead, the other managers were new to the service. Staff we spoke with were clear about their role and responsibilities at the centre and who they reported incidents and issues to. However it was not clear how learning was shared with all clinical staff.

Clinical governance within the centre was supported by the provider's clinical governance processes, this included learning identified across the organisation being shared through newsletters and clinical updates. The managers had regular meetings with the CCG to review performance. Attendance at meetings with the emergency department had not been possible due to the level of staff vacancies, however new staff were being recruited which would enable this to be prioritised.

There was a programme of audits, but we were provided with no examples of any that had been through a full audit cycle and the provider was unable to demonstrate whether any of these audits had led to improvements in patient care. We saw reviews of the number of staff hours provided and number of patients seen had been completed in October 2014 and April and May 2015. More staff hours had been provided to help reduce the time patients had to wait and the number of breaches.

Risk assessments regarding the premises were completed by the hospital trust and the centre had access to these documents when required.

The provider had a range or polices to support staff including induction, sickness and whistleblowing. There were induction handbooks for clinical and administrative staff, to ensure they were given the information they needed to carry out their role. Staff had access to training and development, although they told us that this was not specific for working in an urgent care centre.

Leadership, openness and transparency

There were a range of managers who oversaw different parts of the service including a manager of the centre, a clinical lead, nurse lead and office managers who were responsible for staff recruitment, staff training and appraisals, dealing with complaints and seeking feedback from patients. These managers were visible and available to staff during our visit. There had been a number of new staff recruited in the past few months. New staff completed an induction to the service.

There had been limited opportunities for staff meetings in the past six to eight months and the service were looking at how best to involve staff.

Practice seeks and acts on feedback from its patients, the public and staff

The service told us they were working to improve how they got feedback from patients. They used the Friends and Family test to seek feedback from patients, although there had been limited responses this year. Responses were reviewed at the clinical governance meetings.

The service was looking at how best to communicate and seek feedback from staff as currently formal staff meetings did not take place. At the time of our inspection no plans had been put into place.

Management lead through learning and improvement

Incidents and complaints were reviewed and investigated, but not all staff were aware of outcomes and learning from these. Staff told us they did not have opportunities for meetings as none were formally arranged. This had impacted on their ability to discuss learning from significant events and complaints. Senior staff told us they were in consultation with staff about how best to communicate with them.

While systems were in place to report incidents and identify risks, these were not easily accessible to clinical staff and information was not clearly disseminated to staff.

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured proper and safe management of medicines, because daily records were not available to confirm the temperature of medicine fridges. In addition records were not maintained of cancelled prescriptions. This was in breach of regulation 12(1)(2)(g) 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 We found that the registered person did not ensure that systems and processes were operated effectively to assess, monitor and improve the quality of the service. There was no evidence of improvements being made following clinical audits and there was limited evidence of learning from complaints. The registered person did not assess, monitor and mitigate the risks relating to the health and safety of service users. The systems and processes for recording of significant events was not easily accessible to staff and there limited evidence to demonstrate how lessons were learnt with relevant staff. The registered person did not seek and act of feedback from relevant persons and other persons on the services provided. Staff were not being engaged with formally and there was limited multidisciplinary working. This was in breach of regulation 17(1)(2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that persons employed by the service had received appropriate training as is necessary to enable them to carry out the duties they are employed to perform. Not all GPs had completed child protection training to Level 3, in line with national guidance. This was in breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.