

# King George's EUCC

## Quality Report

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Date of inspection visit: 5 April 2018

Date of publication: 22/08/2018

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

Inadequate



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive to people's needs?

Good



Are services well-led?

Inadequate



# Key findings

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## Letter from the Chief Inspector of General Practice

**This service is rated as Inadequate overall** (Previous inspection 30 March 2017– Requires Improvement).

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires Improvement

Are services caring? – Requires Improvement

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at King George's Emergency Urgent Care Centre (EUCC) on 5 April 2018. The service is co-located with the Emergency Department of King George's Hospital and is open 24/7. Patients are initially assessed by a nurse and then "streamed" or directed for treatment by the most appropriate clinician: for example at the hospital's Emergency Department or at the EUCC.

This inspection was to confirm that the provider had carried out their plan to meet the legal requirements in relation to breaches in regulations that we identified in our previous inspection on 30 March 2017. At that time the service was rated as requires improvement for effective, caring and well led services; and rated overall as requires improvement. This report covers our findings in relation to those requirements and also in relation to additional findings made since our last inspection.

At this inspection we found:

- The provider's clinical streaming process did not safely assess, monitor or manage risks to patients.
- Although we saw evidence that the provider learned from safety incidents and improved its processes, we could not be assured that learning included all relevant people.
- The delivery of high quality care was not assured by the governance arrangements in place. For example, nursing staff induction documents were not readily available and medicines audits lacked a clear process for managing clinicians who persistently breached local prescribing expectations.
- We also noted that clinical meetings were informal and infrequent.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Action had been taken since our last inspection such that clinical audit was now being used to drive quality improvements.
- Staff treated patients with compassion, kindness, dignity and respect. However, there was no system to seek patient's feedback. Three of the eight CQC comment cards completed by patients in the weeks leading up to the inspection indicated patients did not always feel they were treated with respect upon arrival at the centre.
- Records confirmed that the provider's NHS Trust landlord was shortly due to commence reception area building improvement works in response to

# Summary of findings

privacy and confidentiality concerns highlighted at our last inspection. Shortly after our inspection we were sent evidence confirming that the works had commenced.

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

- 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.

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

- Review its medicines management protocols relating to checking expiry dates, prompt access to emergency medicines and also relating to clinicians who breach local prescribing expectations.
- Review the training needs of non clinical staff in response to patient feedback.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

# King George's EUCC

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a CQC pharmacist specialist adviser, a CQC nurse specialist adviser and a CQC governance specialist adviser.

## Background to King George's EUCC

King George's Emergency Urgent Care Centre (EUCC) is an urgent care service available to anyone living or working in Ilford and the surrounding areas in the London Borough of Redbridge. The service is co-located on one level with the Emergency Department of King George's Hospital and is fully accessible to those with limited mobility. The service is delivered by The Partnership of East London Cooperatives (PELC) Ltd.

The centre is a 24/7 NHS walk-in service for patients who consider that their condition is urgent enough that they

cannot wait for the next GP appointment and initially entails a clinician assessing and then "streaming" or directing a patient for treatment by the most appropriate clinician: for example at the hospital's emergency department or at the EUCC.

On site, the EUCC service is led by a service manager and a lead GP who has oversight of the urgent care centre. The service employs doctors, nurses and streaming nurses. The majority of staff working at the service are either bank staff (those who are retained on a list by the provider and who work across all of their sites) or agency staff.

The urgent care service is open 24 hours a day and on average sees 630 patients per week. Patients may contact the urgent care service in advance of attendance but dedicated appointment times are not offered.

This inspection was to confirm that the provider had carried out their plan to meet the legal requirements in relation to breaches in regulations that we identified in our previous inspection on 30 March 2017. At that time we identified breaches in regulations such that the service was rated as requires improvement for providing effective, caring and well led services; and was overall rated as requires improvement.

# Are services safe?

## Our findings

**We rated the service as inadequate for providing safe services.**

### Safety systems and processes

We looked at the systems in place designed to keep people safe and safeguarded from abuse.

- The provider had safety policies, including Control of Substances Hazardous to Health (COSHH) and Health & Safety policies, which were regularly reviewed. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. For example, an infection prevention and control audit had taken place within the previous 12 months and actions taken as necessary.
- The provider's NHS Trust landlord ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The landlord also ensured there were systems in place for safely managing healthcare waste.

### Risks to patients

We looked at systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

### Information to deliver safe care and treatment

We looked at how staff used information they needed to deliver safe care and treatment to patients.

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

### Appropriate and safe use of medicines

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

- Medicines were stored in a locked cabinet inside a locked room with access only given to authorised persons. We noted that the room was small and lacked ventilation; and that this therefore increased the risk of medicines being stored at an increased temperature. Staff members were unaware of the limits of temperature monitoring of medicines and were unsure of what to do in the event of an increased temperature.
- The systems and arrangements for managing medical gases and associated equipment minimised risks.
- Emergency medicines were available but we noted that prompt access would be hindered because they were stored with other medicines.
- The service kept prescription stationery securely and monitored on site usage. Recent training had been undertaken as a result of a prescription incident and a new system of monitoring prescriptions was also in place. However, we noted there were no records of

## Are services safe?

prescription distribution and transportation. In addition, the service was not using prescription form FP10REC which is required by out of hours providers for the supply of medicines from stock direct to patients.

- The service carried out regular medicines audits to ensure prescribing was safe and in line with best practice guidelines. However, we noted the absence of a process for managing clinicians who persistently breached local prescribing expectations.
- For example, between December 2017 and March 2018 the provider undertook two prescribing audits to ensure that doctors were prescribing the minimum possible quantities and strengths. The audits highlighted that a doctor had prescribed quantities which were outside the provider's Medicines Management Policy guidance for safe prescribing.

However, we noted that the doctor had not responded to requests to comment on their prescribing patterns and that the provider had not taken subsequent to ensure safe prescribing. Shortly after our inspection we were sent confirming evidence that the doctor had emailed the provider advising that they would not be prescribing Controlled Drugs.

- The service had audited antimicrobial prescribing and there was evidence of actions taken to support good antimicrobial stewardship.
- We looked at a selection of medicines and noted that they were within their expiry dates. However, the service lacked a process for undertaking regular checks.
- Written instructions (known as Patient Group Directions) for the supply or administration of medicines to groups of patients who may not be individually identified before presentation were on file and appropriately signed.

### Track record on safety

The service's clinical streaming systems, processes and practices were not always reliable or appropriate to keep people safe. For example:

- Streaming clinicians' ability to identify serious illness such as Sepsis were hindered by a lack of blood pressure monitors or child oxygen saturation probes in clinical rooms.

- We highlighted concern regarding the level of detail contained in the service's "Clinical Policy for Emergency and Urgent Care" streaming protocol document in that it failed to reference Sepsis.
- We also identified concern regarding the service's assessment protocol, whereby streamers completed a visual assessment form but left a 'clinical observations' column blank to be completed at the next stage by a Health Care Assistant (HCA), prior to the patient's consultation. As there was not a specified time frame from when the patient was seen and initially assessed by the clinician to when the observations were taken and recorded by the HCA, this gap presented a cause for concern.
- For example a patient presenting with a seemingly minor illness and systemically well may in a short space of time deteriorate. If they were waiting for observations to be recorded this could place the patient at risk of receiving inappropriate care. In some cases, such as Sepsis this delay could compromise life.

We saw evidence that staff were sent communications about medicines and devices alerts through email and via newsletter but we noted the absence of a system for confirming that emails had been received and read by recipients.

### Lessons learned and improvements made

Although we saw evidence that the provider learned from safety incidents and improved its processes, we could not be assured that learning included all relevant people.

We looked at how the provider shared the learning from significant events and used this information to improve or maintain patient safety. Prior to our inspection we asked the provider to forward details of all significant events logged within the previous 12 months. We were initially advised that no such incidents had been recorded. It was later clarified that in 2017 a new protocol had been introduced whereby any incident which reached a specific threshold was required to be investigated by the provider's Clinical Commissioning Group.

During our inspection, we were initially told that one such event had occurred within the previous 12 months. Staff later clarified that this significant event related primarily to a local 111 service provider. Records showed that between August 2017 and January 2018, the CCG and the provider had held three significant event review meetings.

## Are services safe?

We noted the absence of an effective system for collating and sharing learning from those incidents which were less serious and which therefore did not meet the threshold for a CCG investigation. For example, records showed that the provider produced a quarterly bulletin which shared learning from incidents but when we spoke with two GPs they could not recollect any recent significant events. We also noted that clinical meetings (which offered an opportunity to share learning from incidents) were informal and infrequent.

When we spoke with other clinical staff they told us that they received occasional emails regarding adhering to protocols but that they were unaware of any recent significant events. They also told us that meetings discussing specific incidents were infrequent. Reception staff told us that although they logged incidents, they did not receive feedback on the outcome and on how these incidents had been used to improve patient safety.



# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the service as requires improvement for providing effective services.**

**At our previous inspection on 30 March 2017, we rated the practice as requires improvement for providing effective services because of an absence of two cycle clinical audit and appraisals of streaming staff.**

**When we undertook a follow up inspection on 5 April 2018, we saw evidence that appraisals and two cycle clinical audit were now taking place but also that the provider had not taken action where clinical audit results showed only minimal improvement in patient outcomes. The service is rated as requires improvement for providing effective services.**

### Effective needs assessment, care and treatment

The provider had some systems in place to keep clinicians up to date with current evidence based practice (for example a GP forum and a regular newsletter). We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and we were told used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed through the use of clinical audit.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff assessed and managed patients' pain where appropriate.

### Monitoring care and treatment

The service used key performance indicators (KPIs) that had been agreed with its clinical commissioning group to monitor performance and improve outcomes for people. The service shared with us the performance data from April 2017 to March 2018 that showed:

- Between 97% and 99% of people who arrived at the service completed their treatment within four hours. This was better than the target of 96%.
- The service was meeting its target for ensuring that 100% of people treated at the service had their episode of care reported to their GP within 48 hours of discharge.
- Between 32% and 89% of people seen had the completeness and accuracy of NHS numbers checked. This was worse than the target of 95%.

The service made improvements through the use of completed audits. Four clinical audits had taken place within the previous 12 months. We noted that these audits were clinically relevant to an urgent care setting and saw evidence of how they had positively impacted on quality of care and outcomes for patients.

For example, in April 2016, the service audited compliance with NICE best practice regarding documenting vital signs in under five year olds where fever was suspected. The first cycle highlighted that of the 74 cases reviewed 25 cases (34%) had vital signs documented. Following discussion at a GP forum and audit group meetings, a December 2017 re-audit highlighted that only 34 (49%) of the 69 cases audited met the standard. We did not see evidence of actions subsequently taken to improve the documentation of vital signs.

### Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff and which covered such topics as safeguarding.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained although these were not readily available and were only provided shortly after our inspection. Staff were encouraged and given opportunities to develop.
- The provider provided staff with ongoing support. This included one-to-one meetings, coaching and



# Are services effective?

## (for example, treatment is effective)

mentoring, clinical supervision and support for revalidation. An absence of clinical streamer appraisals had been identified as an area of concern at our March 2017 inspection. At this inspection, appraisals documentation was not immediately available but was sent to us shortly after our inspection. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making.

### Coordinating care and treatment

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

- Staff communicated promptly with patients' registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

### Helping patients to live healthier lives

As an urgent care centre, the service did not have continuity of care to support patients to live healthier lives in the manner of a GP practice. However, we saw the service demonstrate their commitment to patient education and the promotion of health and wellbeing advice.

The service was not commissioned to provide screening to patients such as chlamydia testing or commissioned to care for patients with long term conditions such as asthma or diabetes. Only limited vaccinations were provided at the service. These were provided as needed and not against any public health initiatives for immunisation.

### Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

# Are services caring?

## Our findings

**We rated the service as requires improvement for caring.**

**At our previous inspection on 30 March 2017, we rated the practice as requires improvement for providing caring services. This was because space restrictions hindered privacy and confidentiality in reception.**

**When we undertook a follow up inspection on 5 April 2018 records showed that the provider had been liaising with its NHS Trust landlord regarding building improvement works and shortly after our inspection we were sent evidence which confirmed that these works had commenced. The service is rated as requires improvement for providing caring services.**

### Kindness, respect and compassion

We looked at the extent to which staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. We were told that they displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.
- However, we also noted that three of the eight patient Care Quality Commission comment cards provided negative feedback on reception staff. We further noted that at the time of our inspection the provider was not collecting patient feedback regarding the compassion displayed by staff.

### Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care. For example:

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception area, including in languages other than English, informing patients this service was available.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

### Privacy and dignity

When we inspected in March 2017, we noted that the premises were inappropriate for clinical streaming in that they lacked sufficient space to enable initial patient assessments to be conducted in private. We asked the provider to take action.

At this inspection records showed that the provider had been liaising with its NHS Landlord regarding building improvements and shortly after our inspection we received photographic confirmation that building improvement works had commenced.

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times. For example, we were told that whilst building improvement work being planned, patients were offered assessments in adjoining clinical rooms.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### We rated the service as good for providing responsive services.

The service worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. We found the service was responsive to patients' needs in and had systems to maintain the level of service provided.

The service understood the needs of the local population. For example, the service provider was also commissioned to provide an out of hours service from the same hospital location. When we spoke with a commissioner, they indicated that the urgent care centre was an essential service helping to ease pressure on hospital Emergency Departments; and deliver rapid, appropriate care to patients at their time of need.

### Responding to and meeting people's needs

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

- Consultations were not restricted to a specific timeframe so clinicians were able to see patients as long as was necessary.
- The urgent care centre offered step free access and all areas were accessible to patients with reduced mobility.
- The waiting area for the urgent care centre was large enough to accommodate patients with wheelchairs and pushchairs; and also allowed for access to consultation rooms. There was enough seating for the number of patients who attended on the day of the inspection.
- Toilets were available for patients attending the service, including accessible facilities with baby changing equipment.
- Beverages and light snacks were available.

### Timely access to the service

The urgent care service was open 24 hours a day seven days per week. Patients could not book an appointment but could attend the centre and wait to see a nurse or GP. The opening hours of the service meant that patients who

had not been able to see their GP during opening hours could attend for assessment and treatment at any time. The service was accessible to those who commuted to the area as well as residents.

- When patients arrived at the centre there was clear signage which directed patients to the reception area. Patient details (such as name, date of birth and address) and a brief reason for attending the centre were recorded on the computer system by a nurse streamer who would also complete a visual assessment (including a brief set of safety questions) to determine 'red flags' which might mean the patient needed to be seen by a clinician immediately. 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. Nurse streamers and reception staff informed patients about anticipated waiting times.
- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited.
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs. For example, the patient's own GP or a local pharmacist.

### Listening and learning from concerns and complaints

We looked at how complaints and concerns were used to improve the quality of care.

- Information about how to make a complaint or raise concerns was available.
- The complaint policy and procedures were in line with recognised guidance. Twelve complaints were received since April 2017 (ninety three complaints for the combined UCC, 111, out of hours services). We found that complaints were satisfactorily handled in a timely way.

# Are services responsive to people's needs?

(for example, to feedback?)

The service also learned lessons from individual concerns and complaints; and from an analysis of trends at monthly operational meetings.

# Are services well-led?

Inadequate 

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

## Our findings

**We rated the service as inadequate for leadership.**

### Leadership capacity and capability

- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. However, they were unaware of the safety risks associated with the service's clinical streaming process and also had not taken action in relation to governance issues identified at our March 2017 inspection (such as ensuring affective monitoring of the service's clinical risk register).
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.

### Vision and strategy

We were told that the service had a clear vision to create a health care system that provided clinical excellence, patient-focussed and centred, culturally competent, cost effective care with exceptional outcomes and patient satisfaction.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with integrated urgent care priorities across the region. The provider worked with commissioners to meet the needs of the local population.

### Culture

We looked at the culture of the service:

- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- The service aimed to focus on the needs of patients.
- Staff felt respected, supported and valued. They were proud to work for the service.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

- There were positive relationships between staff and teams.

### Governance arrangements

The delivery of high quality care was not assured by the governance arrangements in place. For example:

- The provider's clinical streaming process did not safely assess, monitor or manage risks to patients.
- Although we saw evidence of how the provider learned from safety incidents, we could not be assured that this learning included all relevant people. For example, clinical meetings were informal, infrequent and therefore offered limited opportunities to share learning.
- Although the service carried out regular medicines audits to ensure prescribing was safe and in line with best practice guidelines, we noted that auditing arrangements lacked a clear process for managing clinicians who persistently breached local prescribing expectations.

### Managing risks, issues and performance

We looked at processes for managing risks, issues and performance.

- The provider operated a clinical risk register in order to monitor and address risks. We noted that "poor learning and action from incidents" was listed as a risk area and that some tasks had been undertaken (such as the introduction of a patient safety newsletter). However, we also noted limited opportunities for discussing and sharing learning from significant events. We therefore could not be assured that an effective system was in place for managing risks.
- We also noted the absence of a system for collating and sharing learning from incidents which were below the CCG's significant event threshold. This meant that issues which potentially threatened the delivery of safe and effective care were not being identified or adequately managed.
- We saw evidence that staff were sent communications about medicines and devices alerts through email and via newsletter but we noted the absence of a system for confirming that emails had been received and read by recipients.

# Are services well-led?

Inadequate 

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

- Performance was shared with staff and the local CCG as part of regular contract monitoring arrangements.

## **Appropriate and accurate information**

The service acted on appropriate and accurate information.

- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

## **Engagement with patients, the public, staff and external partners**

We looked at how the service involved staff and external partners to support high-quality, sustainable services.

- Staff were able to describe to us the systems in place to give feedback (such as a quarterly staff fora).

- The service was transparent, collaborative and open with stakeholders about performance. This was confirmed in discussions with the service's CCG commissioner.

- However, we noted minimal engagement with people who used the service (for example through patient surveys).

## **Continuous improvement and innovation**

There were systems and processes for learning and continuous improvement.

- Staff knew about improvement methods such as clinical audit and had the skills to use them.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

## Enforcement actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulation was not being met:</b></p> <ul style="list-style-type: none"><li>• The provider's clinical streaming protocol did not safely assess, monitor or manage risks to patients.</li><li>• The service did not have the appropriate equipment to support the streaming of patients effectively.</li></ul> <p>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>How the regulation was not being met:</b></p> <ul style="list-style-type: none"><li>• The provider did not have appropriate systems in place to ensure that learning from significant events included relevant people and to ensure that feedback from relevant persons was sought and acted upon.</li></ul> <p>This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>