CareQuality Commission

St Mary's Urgent Treatment Centre

Inspection report

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

Ratings

Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at St Mary's Urgent Care Centre (now named St Mary's Urgent Treatment Centre) on 13 July 2017. The overall rating was inadequate, and the provider was placed in special measures for a period of six months. In addition, we took enforcement action in the form of a warning notice in respect of good governance.

We carried out an announced focused follow-up inspection on 22 August 2017 to check that the necessary improvements had been made in respect of the warning notice, or whether further enforcement action was required. At the inspection we found improvements had been made to prevent further enforcement action.

We carried out an announced comprehensive inspection on 27 March 2018 to follow-up on the comprehensive inspection undertaken on 13 July 2017. We found the provider had made considerable improvements and was taken out of special measures. However, we found some areas of non-compliance in respect of good governance and the provider was rated requires improvement overall.

The comprehensive report for the July 2017 inspection, the focused follow-up inspection in August 2017 and the report of March 2018 can be found by selecting the 'all reports' link for St Mary's Urgent Treatment Centre (UTC) on our website at www.cqc.org.uk.

This inspection, carried out on 5 June 2019, was an announced comprehensive inspection to review in detail the actions taken by the provider since our March 2018 inspection to improve the quality of care and to confirm that the provider was now meeting legal requirements.

At this inspection we found:

- The provider had addressed the findings of our previous inspection and was able to demonstrate improvement in performance and resilience in relation to substantive staffing and performance against national targets.
- Although the service had systems in place to manage risk so that safety incidents were less likely to happen they had failed to facilitate formal training to non-clinical reception staff at the point of entry to the service in A&E and the UTC to assure themselves that staff could adequately recognise emergency symptoms.
- There were systems in place to safeguard children and vulnerable adults from abuse and staff we spoke with knew how to identify and report safeguarding concerns. All staff had been trained to a level appropriate to their role.
- There was an open and transparent approach to safety and systems were in place for recording, reporting and sharing learning from significant events.
- The service reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- There was a programme of quality improvement including clinical audit which had a positive impact on quality of care and outcomes for patients.
- Staff had the skills, knowledge and experience to deliver effective care.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- The service took complaints and concerns seriously to improve the quality of care. However, some response times to complainants were outside national guidance.
- Leaders demonstrated they had the capacity and skills to deliver high-quality, sustainable care.
- The provider engaged with patients and staff to improve the service.
- The provider was aware of the duty of candour and examples we reviewed showed the service complied with these requirements.
- There was a focus on continuous learning and improvement at all levels of the organisation.

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

- Ensure care and treatment is provided in a safe way to patients.

Overall summary

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

- Review the frequency of basic life support training for non-clinical staff in line with guidance.
- Continue to monitor waiting times and delays following triage to the UTC to capture any theme or trend to better improve the patient experience.
- Continue to review and monitor the governance oversight of the complaints response process to ensure these are managed within the appropriate timeframes.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to St Mary's Urgent Care Centre

St Mary’s Urgent Treatment Centre (UTC) is commissioned by Central London Clinical Commissioning Group (CCG) to provide an urgent care service within north-west London. The service is located within St Mary’s Hospital, Paddington which is run by Imperial College Healthcare NHS Trust. The UTC premises are owned by the hospital trust.

The service is provided by Vocare Limited who were awarded the contract in April 2016 following a procurement and tender process. The service had previously been run by the trust. Vocare, founded in 1996, is a national provider with headquarters in North East England and provides GP out-of-hours and urgent care services to more than 4.5 million patients nationally. St Mary’s UTC is managed and overseen by Vocare’s London regional management structure headed by a regional director within the national corporate organisational structure. The local management team in the centre comprises of an operational and clinical service manager, a local medical director, supported by two lead clinicians and an assistant clinical service manager. The provider told us that their contract had recently been extended by their commissioners for a further two-year period.

The UTC is open 24 hours a day, seven days a week including public holidays. No patients are registered at the service as it is designed to meet the needs of patients who have an urgent medical concern but do not require accident and emergency treatment, such as non-life threatening conditions. Patients attend on a walk-in basis. Patients can self-present or they may be directed to the service, for example by the NHS 111 service or their own GP. The service is GP-led with a multi-disciplinary team consisting of emergency department doctors, advanced nurse practitioners (ANPs), nurse practitioners (NPs), emergency nurse practitioners (ENPs) and emergency care practitioners (ECPs).

The UTC provides assessment and treatment of minor illness and minor injuries for adults and children. Reception staff at the point of entry to the service (A&E department) and paediatric initial assessment (streaming) is currently sub-contracted to the hospital trust that provide these functions on behalf of the provider.

The provider is operating within a commissioned clinical and operational model for patients attending the UTC which requires patients to initially present to the A&E department where they are streamed by a clinician to determine their care pathway. If the pathway is to be seen at the UTC then the patient is directed to separately located premises. The UTC is accessible by both an internal and external route within the hospital trust estate which takes approximately 10 to 30 minutes to walk dependent on pace, ambulatory capability or whether an internal or external route is chosen.

The patient activity at the UTC is approximately seventy-one thousand patients per year.

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services. This is because:

- **The provider had not facilitated formal training to non-clinical reception staff at the point of entry to the service in A&E and the UTC to assure themselves that staff could adequately recognise emergency symptoms, for example sepsis.**

Safety systems and processes

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

- The provider had systems to safeguard children and vulnerable adults from abuse. There was a local safeguarding lead and an organisation-wide strategic safeguarding lead.
- There were policies covering adult and child safeguarding which were accessible to all staff, both substantive and locum, and regularly reviewed. They outlined clearly who to go to for further guidance.
- Staff we spoke with demonstrated that they could access policies and procedures and had access to safeguarding pathways and flowcharts. We also saw these were displayed in consultation rooms.
- Clinical and non-clinical staff we spoke with knew how to identify and report concerns. We saw that referrals were made through local processes but also recorded on the providers incident reporting and risk management software. We saw that learning from safeguarding was cascaded through a monthly clinical bulletin.
- We saw evidence that clinical and non-clinical staff had received safeguarding children and adult training appropriate to their role. The service had mechanisms in place to flag when update training was required and sent reminders to staff.
- The service worked with other agencies to support patients and protect them from neglect and abuse. The service had links with the Clinical Commissioning Group (CCG) safeguarding lead and attended local safeguarding board meetings. The provider utilised the Child Protection – Information Sharing (CP-IS) project which enabled health and social care staff to share information securely to better protect the most vulnerable children.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. We spoke with the provider's human resources director and head of workforce management and were able to access the recruitment database to review employment files for non-clinical, doctor and nurse staff members. We saw appropriate checks had been carried out at the time of recruitment. For example, interview notes, proof of identification, qualifications, references, registration with appropriate professional body, inclusion on a performer's list, medical indemnity and appropriate Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Staff vaccination was maintained in line with current Public Health England (PHE) guidance.
- Staff who acted as chaperones were trained for the role and had received a DBS check. Staff we spoke with on the day understood their role as a chaperone. Patient information regarding the availability of a chaperone service was available in several languages in the waiting area.
- There was an effective system to manage infection prevention and control (IPC) which included a nominated IPC lead, training for all staff relevant to their role and regular audit. The hospital trust cleaning team was responsible for cleaning the premises and we saw that appropriate standards of cleanliness and hygiene were maintained.
- The premises were managed and maintained by the hospital trust's facilities management team. We saw various risk assessments had been carried out which included legionella and fire.
- We saw evidence that fire awareness training had been undertaken by both clinical and non-clinical staff. Staff we spoke with knew the location of the fire evacuation assembly point and told us a fire evacuation drill had been undertaken in December 2018. The provider had recorded this. The fire alarm was tested weekly and logged.
- Staff told us they received safety information from the service as part of their induction and on-going training which included health and safety and moving and handling.
- The provider ensured that medical equipment was safe and maintained according to manufacturers' instructions. We saw evidence that annual calibration had been undertaken in March 2019.

Requires improvement

Are services safe?

- There were systems for safely managing healthcare waste.

Risks to patients

- There were arrangements for planning and monitoring the number and mix of staff needed. We reviewed performance data provided to the service's commissioners and saw that its workforce delivery (rota fill) data from April 2018 to January 2019 ranged from 96% to 100% with 100% attainment seen for GPs and nurses for December 2018 and January 2019. In addition, we saw that the service's substantive to agency staff mix had improved since 2017. At our last inspection we found that permanent staff levels were at 67%. At this inspection, we saw data over the year which demonstrated that substantive staff now accounted for 81% of its workforce.
- There was an effective induction system for temporary staff tailored to their role.
- The provider had a service escalation plan to manage situations where the service demand outstripped the resources available to safely manage cases requiring streaming/triage and/or requiring assessment and management in the UTC and in the A&E. The provider held situation report meetings with the trust at three intervals throughout the day to monitor clinical and operational pressures.
- Patients presenting to A&E were streamed by a UTC clinician to determine their care pathway in line with a formal streaming and triage clinical protocol. The provider had a system in place to facilitate prioritisation according to clinical need where more serious cases could be prioritised as they arrived.
- Paediatric streaming was sub-contracted to the trust and there was a separate designated child-friendly waiting area.
- Clinical staff we spoke with understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. We saw that guidance was readily available in all consultation rooms, for example how to identify symptoms and treatment of sepsis. Each clinical room had equipment for the assessment of sepsis, for example, adult and paediatric pulse oximeters, blood pressure machine and thermometer.
- Non-clinical staff we spoke with demonstrated some awareness of 'red flag' presenting complaints, for example patients with shortness of breath and what action to take if they encountered a deteriorating or acutely unwell patient. However, staff we spoke with could not recall any recent formal training which included sepsis. Reception staff at the point of entry to the service in the A&E department were subcontracted from the trust and it was the provider's responsibility to ensure effective training had been delivered. The provider confirmed that this had not been undertaken. After the inspection, the provider sent evidence that formal emergency symptom recognition training had been undertaken for three out of 13 reception staff in A&E. The training included chest pain, bleeding, respiratory distress, stroke and sepsis in children and adults.
- The service had adequate arrangements in place to respond to medical emergencies. The UTC was located within the hospital trust estate and operated within its emergency response protocol through the standard crash call telephone number. There was a resuscitation trolley within the centre which was easily accessible and stocked identically to those within the hospital trust to ensure consistency. We saw there was a defibrillator available and oxygen with adult and children's masks. All equipment and medicines on the resuscitation trolley were checked daily and we saw evidence of a check list.
- At the time of our inspection we saw that 86% of doctors and 100% of nurses had undertaken annual resuscitation training. We saw that there were systems in place to alert staff when an update was due and those due for an update had been flagged. We saw that 80% of non-clinical staff had undertaken basic life support training, but some training had exceeded a 12-month update. The provider did not have BLS training on an annual requirement for non-clinical staff. Resuscitation Council guidelines recommend that non-clinical staff should have annual updates, or a local risk assessment undertaken to assess the likelihood of them encountering a patient requiring resuscitation, if a decision had been made not to provide annual updates. All non-clinical staff within the UTC and in A&E had roles which involved direct patient contact.
- Staff told patients when to seek further help and advised patients what to do if their condition got worse.

Are services safe?

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

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. We reviewed random care records, and these showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, special notes were available, and alerts were added to the system for patients identified as vulnerable. A summary of the care provided was shared with patients' GPs.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The service complied with the Data Protection Act 2018, including General Data Protection Regulation (GDPR). We saw that staff had undertaken data security awareness training.

Appropriate and safe use of medicines

On the day of the inspection we found that the service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- The service did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- The service did not dispense any medicines, for example 'to take out' (TTO) medicines (pre-packed and pre-labelled medicines) for patients. All patients were given a prescription or directed to pharmacy for over-the-counter (OTC) medicines.
- There was a small dedicated medicines storage refrigerator with built-in thermometer and we saw evidence that the minimum, maximum and actual temperatures were recorded daily. There was no secondary thermometer, independent to the integral thermometer, available in line with Public Health England (PHE) guidance. We found that the fridge was small and very full which may have an impact on air circulation within the fridge. After the inspection the provider told us they had ordered a secondary thermometer and an additional medicines storage refrigerator.
- The service kept prescription stationery securely and monitored its use. The provider had undertaken an audit to review the risk of prescriptions being unaccounted for, discarded/spoiled or stolen. The outcome of the audit was to use one centralised, monitored and secure dedicated printer for all prescriptions generated. The provider told us this had had a positive impact on the process of controlling and monitoring prescriptions. The provider had a contingency in place for failure of the printer.
- The service had carried out some prescribing audits which included a two-cycle antibiotic prescribing for urinary tract infections and sore throats audit and a two-cycle diazepam prescribing audit.
- Staff we spoke with demonstrated they prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, it was unclear which antibiotic prescribing guidance was used as some clinicians told us they used the local prescribing guidelines, and some told us they used the National Institute for Health and Care Excellence (NICE) guidance. The provider confirmed after the inspection that it had changed its antibiotic prescribing guidance to the NICE guidance in February 2019 and advised staff through the monthly clinical bulletin, training updates and guidance in clinical rooms.
- There was a process in place to audit the prescribing of all prescribers. Staff we spoke with told us they received feedback from reviews.

Track record on safety

- The service had acted upon findings of previous inspections and were able to demonstrate improvements, for example, the x-ray monitoring process for missed fractures. In addition, we saw that the service monitored and reviewed its activity through its key performance indicators (KPIs). This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Requires improvement

Are services safe?

- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including locum staff through a monthly bulletin. Staff we spoke with confirmed they received the bulletins.
- There were risk assessments in place relation to safety issues, for example premises and equipment.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- The provider demonstrated its system for recording and acting on significant events. There was an incident policy and all categories of incident were recorded on its incident reporting and risk management software.
- Staff we spoke with understood their duty to raise concerns and report incidents and near misses and knew how to do this.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. The service demonstrated it shared lessons and outcomes through monthly email bulletins from the local Clinical Director to all substantive and agency staff. We reviewed the content of bulletins from March, April and May 2019 and saw several examples of shared learning. Both clinical and non-clinical staff we spoke with confirmed they received bulletins and were able to give examples of recent learning.
- At our previous inspection the provider was unable to demonstrate sufficient oversight of the reporting process to ensure significant events were managed in the appropriate timescale. At this inspection we saw that a regional level of oversight had been implemented through a serious case initial findings (SCIF) process facilitated by the regional governance team to ensure information gathering and coordination took place in a timely manner. The provider had also facilitated additional root cause analysis training to some staff to increase the pool of resource locally and across the organisation.
- The provider had daily risk meetings where issues such as incidents were discussed in real-time.
- The provider held a risk register and we saw that all identified risks had been assessed to define the level of risk by considering the category of probability against the category of impact on the service. All risks had been allocated a RAG (red, amber, green) rating based on this assessment.
- We saw evidence that the provider shared incidents with its commissioners in its monthly quality report. The report outlined incidents captured, any identified trends and action taken.
- The provider also had processes in place to share information with other organisations such as the National Reporting and Learning System (NRLS) and the Care Quality Commission (CQC).

We saw evidence that the provider had complied with the Duty of Candour (a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was a patient leaflet to guide patients and carers on the Duty of Candour requirements and process.

Good

Are services effective?

At our previous inspection on 27 March 2018, we rated the provider as requires improvement for providing effective services as they were failing to achieve a performance target which impacted on patients receiving care and treatment in a timely manner and had a potential impact on other services.

At this inspection we found improvements has been made and the provider is now rated as good for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. Guidance and updates were communicated to all substantive and agency staff through monthly email bulletins from the local Clinical Director and staff we spoke with confirmed they received the bulletins.
- The provider monitored that these guidelines were followed through quarterly notes and performance reviews. Staff we spoke with confirmed they received feedback.
- Patients' needs were fully assessed. Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- We saw no evidence of discrimination when making care and treatment decisions.
- Care and treatment were delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, clinicians we spoke with demonstrated the pathways in place for patients presenting with mental health problems.
- There were process in place to identify repeat patients and systems in place to provide appropriate support.
- Staff assessed and managed patients' pain where appropriate. There was a pain scoring tool in place.

Monitoring care and treatment

The service used key performance indicators (KPIs) that had been agreed with its clinical commissioning group to monitor their performance and improve outcomes for people. Performance data, which included staffing levels, training compliance, audit activity, incidents, complaints and patient feedback were provided in a monthly quality report.

The service shared with us the performance data from April 2018 to April 2019, which showed the provider was meeting their targets. For example:

- 96% of adults who arrived at the service were streamed within 20 minutes (target 95%).
- 98% of people who arrived at the service and completed their treatment within four hours (target 95%).

The provider sub-contracted the hospital trust to undertake paediatric streaming. Performance data from April 2018 to April 2019 showed:

- 92% of children who arrived at the service were streamed within 15 minutes (target 95%). We reviewed data for each individual month and saw that the target had been met every month from August 2018 with 100% compliance for January, February and March 2019.

Where the service was not meeting their targets, the provider had put actions in place to improve performance. For example, at our previous inspection we found the provider was failing to achieve the target on re-directs from the UTC to A&E in under two hours. The provider told us that it had met with the trust and had reviewed and amended some of the streaming pathways to improve the process. At this inspection we saw data that showed that the provider had met its target of 90% for the last 10 months with an average of 92%.

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

- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, we reviewed a repeat audit on the x-ray monitoring process for missed fractures which showed that for the period January 2018 to December 2018, 100% of patients with missed fractures identified had been notified within 24 hours.

Good

Are services effective?

- There was a structured programme of local and national audits, both clinical and operational, for 2019-2020 which included antibiotic and diazepam prescribing, safeguarding referrals, adverse events and serious incidents and staff recruitment compliance.

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 which included health and safety, role specific training and policies and procedures.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider maintained up-to-date records of skills, qualifications and training There were mechanisms in place to alert staff when update training was due. The provider reported the statutory and mandatory training compliance rates to its commissioners in a monthly quality report.
- The provider provided staff with ongoing support which clinical supervision, one-to-one meetings and appraisals.
- Quarterly qualitative and quantitative clinical performance reviews were undertaken for all clinicians and there was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

As an UTC the service did not have the continuity of care to support patients to live heathier lives in the way that a GP practice would. Patients typically attended the service with acute episodes of minor illness or injuries requiring urgent attention. However, staff we spoke with told us they were committed to the promotion of good health and were proactive in empowering patients and supporting them to manage their own health and maximise their independence. Performance data for the period April 2018 to March 2019 showed that 100% of patients had received health education, promotion and self-care advice on discharge.

Staff told us where risk factors were identified these were highlighted to their normal care providers through electronic communication or, if urgent, by phone or fax. Where patients' needs could not be met by the service, staff told us they redirected them to the appropriate service for their needs.

Staff told us they encouraged and assisted patients to register with a local GP and we saw patients leaflets in the waiting room which provided guidance and information on how to register with a GP. Performance data for April 2018 to March 2019 showed 100% of unregistered patients had been assisted to register, for example provided with information and relevant contact details.

Consent to care and treatment

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

- Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making.

Good

Are services effective?

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients and treated them with kindness, respect and compassion.

- Staff we spoke with demonstrated they understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- We saw equality and diversity training formed part of the provider's mandatory training schedule and we saw evidence that this had been undertaken by clinical and non-clinical staff.
- We received 10 patient Care Quality Commission comment cards, of which seven were positive, two were mixed and one was negative. Positive comments included good service, reassuring, caring and patients felt they were treated with dignity and respect. The mixed comments and negative comment related to waiting times to be seen.
- The provider also collected patient feedback through the NHS Friends and Family Test:
- Data for the period January 2019, based on 186 responses showed that 60% would be extremely likely to recommend the service and 30% would be likely to recommend the service.
- Data for the period February 2019, based on 104 responses, showed that 61% would be extremely likely to recommend the service and 28% would be likely to recommend the service.
- Data for the period March 2019, based on 103 responses, showed that 50% would be extremely likely to recommend the service and 33% would be likely to recommend the service.
- We did not have the opportunity to speak with any patients in the centre during our inspection.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. Staff we spoke with knew this service was available and how to access it. We saw notices in the waiting area informing patients that an interpretation service was available and there was a language identification poster which assisted staff to identify which language was spoken by a patient.
- The provider had identified the three most common languages requested at the service and produced leaflets aligned to those languages and had installed information screens in the waiting room displaying information about chaperoning, safeguarding, how to make a complaint and fire safety in English and the identified languages.
- Staff communicated with people in a way that they could understand. We saw communication aids, for example, an induction hearing loop and easy read materials were available for patients.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- We observed that there were arrangements to ensure confidentiality at the reception desk. For example, computer screens could not be seen when standing at the reception desk. Staff we spoke with gave examples of how they maintained confidentiality. For example, patient identifiable information not being visible.
- Staff we spoke with told us that if patients were distressed or wanted to discuss sensitive issues they would be taken to a private room.
- Curtains were provided in consulting room to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

- The provider engaged with commissioners and allied healthcare professionals to secure improvements to services where these were identified. For example, in the development of chest pain and deep vein thrombosis (DVT) pathways.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, the standard streaming protocol included a criteria list for patients who should be referred immediately to the emergency department.
- There was a lack of physical space at the UTC. However, we observed that the provider had made improvements since our last inspection and decorated and reconfigured the waiting room. The provider had replaced the seating with more durable and wipeable, high-backed chairs with arms. The seating had been configured so patients were facing away from the reception desk. Television and patient information screens had been installed which included information in several languages aligned to the patient demographic. The provider told us that the trust estate was due to upgrade external signage as part of the UTC way finding pilot. The provider had engaged with Healthwatch (an independent national champion for people who use health and social care services) who had undertaken a site visit with a view to further improve the patient environment and experience.
- The service made reasonable adjustments when people found it hard to access the service. There was ramp access to the service, a disabled access door system, an accessible toilet, interpreter services and an induction hearing loop at the reception desk.

Timely access to the service

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

- Patients were able to access care and treatment at a time to suit them. The service operated 24 hours a day, seven days a week including bank holidays.
- Patients could access the service either as a walk in-patient, via the NHS 111 service (NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs) or by referral from a healthcare professional, such as their own GP.
- The service was provided primarily for patients living in north-west London, but there were no restrictions to access, and the service was utilised by patients transiting through the area via one of the major transport hubs and a significant number of homeless patients. No patients were registered at the service as it was designed to meet the needs of patients who had an urgent medical concern but did not require accident and emergency treatment, such as non-life-threatening conditions.
- The provider was operating within a commissioned clinical and operational model for patients attending the UTC. Access to the service was through A&E which was located within St Mary's Hospital. Patients presented to reception and were recorded on the computer system. Patients were streamed by a UTC clinician to determine their care pathway. If the pathway was to be seen at the UTC then the patient would be directed to the centre. The provider had information for patients on the streaming process by way of a multi-lingual leaflet and clinical streaming sheet to hand in upon arrival at the UTC.
- Paediatric streaming was sub-contracted to the hospital trust. There was a separate waiting room for children in A&E.
- Patients were generally seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived.
- The receptionists informed patients about anticipated waiting times.
- Patients had timely access to initial assessment, test results, diagnosis and treatment. For example, performance data for April 2018 to April 2019 showed that 96% of adults who arrived at the service were streamed within 20 minutes (target 95%) and 98% of people who arrived at the service and completed their treatment within four hours (target 95%).
- Waiting times and delays were one of the main themes in patient feedback and complaints. Some staff also told us that waiting times and delays, at times, was a

challenge to delivering good quality care. It was not a contractual requirement to monitor wait times and delays within the two performance indicators of arrival to streaming within 20 minutes and completion of treatment within four hours. regards wait times and delays in the centre following triage. However, the provider had worked collaboratively with the trust through a working group to analyse transfer and waiting times which had included delays within the UTC.

- Where patients were waiting for a long time in the centre there was visual awareness of the waiting area and signs had been placed in the area advising patients to speak to a receptionist if their condition worsened.

Listening and learning from concerns and complaints

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

- The provider had as system in place for handling complaints. The complaint policy and procedures were in line with recognised guidance and was accessible to staff.
- All complaints were recorded on its incident reporting and risk management software which enabled oversight at local, regional and national level.
- The provider had daily risk meetings where issues such as complaints were discussed in real-time.
- Patient information about how to make a complaint or raise concerns was available in English and other languages which the provider had identified as the common languages requested at the service.
- Staff we spoke with demonstrated that they treated patients who made complaints compassionately.
- We saw that the provider had received 66 complaints in 2018 and up to the time of our inspection, had received 25 complaints in 2019. As part of the provider's complaints management process, acknowledgement and response times to complaints were monitored in line with the NHS England complaints process. Guidance states that all complaints should be acknowledged no later than three working days after the day the complaint was received, and response times should be within 40 workings days unless a different timescale was set with the complainant at the time of the complaint acknowledgment. We found that:
  - 2018: 91% had been acknowledged within the timeframe (three days)
  - 2019: 97% had been acknowledged within the timeframe (three days).
  - 2018: 21% had received a response within the timeframe (40 working days).
  - 2019: 27% had received a response within the timeframe (40 working days).
- We met with the regional governance coordinator who told us where the response timeframe had not been met the complainant received an update on the progress of the complaint. The provider was aware that some complaint targets were not being met and additional governance at a regional level had been implemented to establish consistency and work towards compliance.
- The service analysed complaint trends as we saw that they had identified clinical treatment, staff attitude and behaviours and appointments including delays as the three main complaints. The provider shared complaints with individuals through one-to-one and learning outcomes through the monthly clinical bulletin.

Good

Are services well-led?

At our previous inspection on 27 March 2018, we rated the provider as requires improvement for providing well-led services as they could not demonstrate a formal strategy to provide assurance of resilience to support its priorities for delivery good quality sustainable care.

At this inspection the provider was able to demonstrate that improvements had been made and sustained. The provider is now rated as good for providing well-led services.

Leadership capacity and capability

Leaders on the day demonstrated they had the capacity and skills to deliver high-quality, sustainable care.

- Since our last inspection the provider at organisational level had changed its structure and had implemented national and regional management tiers. Locally the service was supported by a regional leadership team which provided clinical, medical and operational support directly to the centre. The local substantive leadership team consisted of a medical director, supported by two clinical lead GPs, an operational and clinical services manager and an assistant clinical services manager. On the day of our inspection an interim leadership team (operations and medical) was in place as the provider had responded to a human resource matter in line with its internal policies.
- Leaders we spoke with on the day of the inspection demonstrated the experience, capacity and skills to deliver the service strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Staff told us that leaders were visible and approachable. The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

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

- The provider told us their mission was to stabilise current services, sustain quality improvements, support staff and drive innovation and performance to the benefits of their patients.
- To achieve its mission there was a clear set of values which the provider told us was to be patient focused, take ownership of delivery, focus on their people and be forward thinking, responsive and adaptable.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- The service had a realistic strategy and plan to achieve priorities. The strategy was in line with health and social priorities across the region. The provider monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- Staff we spoke with told us they felt respected, supported and valued. Some staff told us they felt the provider listened to them and that there had been improvements over the last year. Staff said it was now a consistent and stable team and they were happy to work at the centre.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included one-to-ones and appraisals. All staff received regular annual appraisals in the last year.
- 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.
- Staff we spoke with told us there were positive relationships between staff at all levels within the team.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management at local and regional level.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.

Are services well-led?

- Staff had lead roles, for example safeguarding, infection prevention and control and there was oversight and support for these roles at regional and national level.
- Staff we spoke with were clear about their roles and accountabilities, and responsibilities in respect of safeguarding, incident reporting and infection prevention and control.
- There was an overarching regional and national governance structure. There was oversight from the regional governance team of incidents and complaints at the centre to improve response times.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

Although the service had processes in place for managing risks they had failed to facilitate formal training to non-clinical reception staff at the point of entry to the service in A&E and the UTC to assure themselves that staff could adequately recognise emergency symptoms.

Since our last inspection the provider had made sustained improvements in its workforce delivery (rota fill) and substantive to agency staff mix to demonstrate resilience in its workforce planning and delivery.

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

Performance of employed clinical staff could be demonstrated through audit of their consultations and prescribing decisions.

Leaders had oversight of patient safety alerts, incidents, and complaints. Additional monitoring had been put in place at regional level to manage the incident and complaints processes.

The provider had processes to manage current and future performance of the service. Leaders we spoke with had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at local, regional and national level. Performance outcomes was shared with staff and commissioners as part of contract monitoring arrangements.

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

The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The provider was actively promoting the NHS Friends and Family Test (FFT) after each clinical episode and within the UTC waiting area.
- Staff we spoke with were able to describe the systems in place to give feedback, for example through one-to-ones and appraisals. Staff told us they felt confident to give feedback to the management team in real-time and felt there was an open and approachable culture.
- The provider engaged with its commissioners and worked in partnership with trust and other external stakeholders, for example the ambulance service in the delivery of the service.

Good

Are services well-led?

- The service was transparent, collaborative and open with stakeholders about performance.
- We saw evidence that the provider had recently engaged with Healthwatch to improve the patient environment and experience.

Continuous improvement and innovation

The provider had put systems and processes in place to promote learning, improvement and innovation.

- We saw that the service had actively engaged with stakeholders to focus on the findings of the previous inspection.
- The service demonstrated it worked in partnership with the trust, for example, to develop effective integrated patient pathways.
- The service made use of internal and external reviews of incidents and complaints and learning was shared and used to make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The provider had failed to facilitate formal training to non-clinical reception staff at the point of entry to the service in A&E and the UTC to assure themselves that staff could adequately recognise emergency symptoms, for example sepsis. **This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**