Hounslow and Richmond Community Healthcare NHS Trust

RY9

Urgent care services

Quality Report

Hounslow Urgent Care Centre
West Middlesex Hospital
Twickenham Road
Isleworth
Middlesex TW7 6AF
Teddington Walk-in Centre
Teddington Memorial Hospital
Hampton Road
Teddington
Middlesex
TW11 0JL
Walk-in Tel: 020 8714 4004, UCC Tel 020 8321 6700
Website: www.hrch.nhs.uk

Date of inspection visit: 1-4 March 2016 (announced) and 11 March 2016 (unannounced)
Date of publication: 06/09/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RY9X3	Hounslow Urgent Care Centre	Hounslow Urgent Care Centre	TW7 6AF
RY9X2	Teddington Memorial Hospital	Teddington Walk-in Centre	TW11 0JL

This report describes our judgement of the quality of care provided within this core service by Hounslow and Richmond Community Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Hounslow and Richmond Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Hounslow and Richmond Community Healthcare NHS Trust.

Summary of findings

Ratings

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 5

Background to the service 6

Our inspection team 6

Why we carried out this inspection 7

How we carried out this inspection 7

What people who use the provider say 7

Areas for improvement 7

Detailed findings from this inspection

The five questions we ask about core services and what we found 8

Action we have told the provider to take 29

Summary of findings

Overall summary

Overall we judged the urgent care services managed by the trust as requiring improvement. The arrangements for the walk-in centre were appropriate for the size and type of service. However, we had some concerns about aspects of the urgent care centre, which was the gateway to the hospital emergency department, and assessed and treated patients with a wider range of ailments and injuries.

- Incident reporting was low and there was limited evidence of action in response to some local audit audits. Findings from audit did not feed into risk management and service improvement nor were information from complaints and incidents communicated widely to staff.
- There were not always sufficient staff at peak times to assess patients, particularly children, promptly, and to treat all adults within four hours.
- The initial assessment process in the UCC was light for a service that made decisions about streaming patients to the hospital emergency department as well as prioritisation within UCC.
- The UCC waiting and treatment areas were not child or family friendly, although we later learned that plans to change this had been approved.
- The shared management of the Urgent Care Centre between the trust and a sub contractor were not clearly understood by all staff. Some staff did not feel actively engaged with the trust or able to suggest change.

However

- At both locations safeguarding arrangements were well understood by staff and staff had completed relevant training in child protection and safeguarding vulnerable adults.
- Patients were generally treated in line with national guidelines
- The arrangements for ordering and safe storage of medicines were appropriate.
- The environment was clean and tidy and infection prevention and control was good.
- Plan were in place to respond to emergency situations.
- Staff enjoyed working at both centres and considered they offered a good service.

Summary of findings

Background to the service

Hounslow and Richmond Community Healthcare Trust provides urgent care services at two locations, one in the Borough of Richmond and one in the borough of Hounslow. The services are of different sizes in terms of numbers of patients and the scope of treatments offered are different.

Teddington Walk-in Centre (WiC), the smaller service, is based at Teddington Memorial Hospital. About half of patients attending are from the borough of Richmond. Other patients attend from neighbouring boroughs and a few from overseas. It is run by Hounslow and Richmond Healthcare Trust under contract from NHS Richmond Clinical Commissioning Group. It provides treatment for patients with minor illnesses or minor injuries including infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains, without appointments. The centre is led by nurses on weekdays until 6.30pm. In the evenings, at weekends and on bank holidays GPs also work at the centre. The centre is open from 8am until 10pm on weekdays and until 9pm at weekends and bank holidays. Doctors and nurses treat 4200 patients a month. About a third of patients are children and 15% of patients are over 61 years.

The walk-in centre has five consultation rooms and a nurse's hub. Some consultation rooms are also used for outpatient appointments, x-rays are available on weekdays between 9am and 7pm and at weekends between midday and 5pm). Chest x-rays are not offered to walk-in patients or to children under two years old. Patients refer themselves to this service or attend because their GP could not offer an appointment. A few patients who call 111 for medical help are directed to this service. A very small number of patients are brought in by ambulance. The service is not intended for patients with a serious injury such as an injury to the head, spine and neck, or for patients with chest pain or acute allergic reaction.The Thames Health Collaborative Community Interest Company (THCCIC) provides GPs for this service.

The Hounslow Urgent Care Centre, (UCC) is on the site of West Middlesex Hospital, (part of Chelsea and Westminster Hospital NHS Foundation Trust) in Isleworth, Hounslow. UCC staff assess all walk-in patients presenting to urgent and emergency care at the hospital. The patients who are clearly critically unwell or badly injured progress straight to the ED (about 15% of walk-in patients). The UCC provides treatment for minor to moderate illnesses or injuries that do not require emergency treatment. The UCC is open 24 hours a day 365 days a year. It treats about 6500 patients each month. One third of the patients are children 56% of the children are under 2 years old, and 8% are over 61 years. The service is staffed by nurses, emergency healthcare practitioners and GPs.

The UCC is provided jointly by the Hounslow and Richmond Community Healthcare NHS Trust (HRCH) and its subcontractor, Greenbrook Healthcare (Hounslow) Limited, (Greenbrook). The service is commissioned by Hounslow Clinical Commissioning Group. In this shared service, HRCH employs nurses, healthcare assistants, and reception staff, and the service operates under the trust's policies. Greenbrook supplies the doctors and provides the onsite management.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh

Team Leader: Nick Mulholland, CQC

The team inspecting the UCC was led by a CQC inspector and included a second CQC inspector, an experience urgent care centre nurse and manager and a pharmacist.

Summary of findings

Why we carried out this inspection

We inspected this provider as part of our comprehensive community health services inspection programme.

How we carried out this inspection

During our inspection, we visited all areas of the walk-in centre, including the x-ray unit shared with the outpatient department. We spoke to 14 patients and 12 staff. We also observed staff delivering care. At the Urgent Care Centre, we visited all areas including the X-ray unit in the hospital ED and spoke with 20 patients and 24 staff including 3 GPs, six nurses, two healthcare assistants, 2 reception staff, and four managers, domestic and security staff. We observed staff interactions with patients in reception and clinical areas, looked at a sample of patient records, and the way medicines were recorded and stored. We observed consultations with patients.

Before the inspection, we looked at data provided by the service such as clinical performance data, policies, and records including serious incident investigations, complaints, and clinical audits.

The CQC held a number of focus groups and drop-in sessions where staff from across the trust could talk to inspectors and share their experiences of working at the trust. We reviewed a variety of documents including 10 sets of care records, audits, minutes from meetings, clinical governance and performance monitoring data. We looked at patient feedback about the service over the past year.

We also requested additional information after the inspection.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

What people who use the provider say

- We reviewed feedback from the patients' family and friends test and comments on the NHS Choices website. We spoke with patients and their relatives and carers.
- The majority of feedback was positive. However, the response to the friends and family tests provided too small a sample to be confident it was representative. However, this information would soon be supplemented by the results of a more in depth survey of attendees.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must improve reporting and analysis of incidents so that lessons can be learned and shared with relevant staff to ensure improvements in the service to patients.

Action the provider COULD take to improve

- Review streaming to protect privacy of patients and ensure sufficiently detailed information is captured at the initial assessment to enable ED referral and safe prioritisation at the UCC.
- Review ways to provide a more child and family friendly service at the UCC.

Hounslow and Richmond Community Healthcare NHS Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Overall we rated the safety of the urgent care services as requiring improvement although this was predominantly because of concerns about the UCC rather than the walk-in centre.

- At the UCC incident reporting was very low and incidents of different kinds, including medication incidents were not being routinely reported, reviewed and used for learning to avoid recurrence. Staff were not all aware of the learning from serious incidents, although the trust was already taking action to emphasise the importance of incident reporting.
- We did not see evidence of nursing staff and General Practitioners learning from incidents to improve the service.
- There was a risk that the quick initial assessment, carried out through a glass screen, might not always be sufficient to guarantee safe decisions on whether a patient should be treated in the UCC or ED, and on prioritisation for treatment within the UCC, particularly when patients did not move quickly to the full clinical assessment.
- Not all advanced nurse practitioners (ANPs) treating children had appropriate training as part of their extended ANP role, although all nurses had basic paediatric training.
- Not all patients were assessed and treated within the optimum time at the UCC. Streaming was assessed against a 20 minute target whereas the national standard for a service seeing walk-in patients that included some for referral to ED was for 95%.
- The arrangements for maintaining and checking the resuscitation trolley at the walk-in centre would benefit from review.
- Secure access to the nursing hub at the walk-in centre and treatment rooms need to be reviewed as there was currently a potential risk to staff and other patients.
- At the UCC not all relevant patients had a full set of baseline observations taken at streaming.

However, at the walk-in centre

- There were systems to protect patients and maintain their safety, including staff understanding of the types of incidents to report, and recording them so the level and range of incidents could be reviewed and managed.

Requires improvement

Are services safe?

- There were sufficient staff to treat patients promptly, and all patients were seen in less than four hours.
- At both centres arrangements for ordering and safe storage of medicines were appropriate.
- Safeguarding arrangements were well understood by staff and staff had completed relevant training in child protection and safeguarding vulnerable adults.
- The environment at both centres was clean and tidy.

Safe track record

- The walk-in centre used a range of information to identify risks and improve patient safety. Managers disseminated safety information through meetings and by email.
- Incidents were reported electronically. There had been no serious incidents at the walk-in centre.
- The UCC drew on internal and external information to improve patient safety. For example, patient safety alerts issued by the Central Alerting System were emailed to the lead GP who was responsible for cascading these to staff. There was no system to ensure that all doctors had read these.
- At the UCC, there had been five serious incidents requiring investigation since June 2014. Two of the serious incidents had involved children under two years of age.
- We reviewed the trust's policy on incidents and information for all staff about incident reporting in the staff handbook. There was a gap between policy and practice.

Incident reporting, learning and improvement

- A review of the incident log at the walk-in centre showed a wide variety of issues covered: staffing levels, aggressive patients, staff injury, and maximum patient capacity reached. Staff reviewed incidents systematically at the operational meeting. An example of learning was a change in the floor layout in the waiting area, following an incident of aggression, which had improved safety.
- At the UCC, incident reporting was not in line with the HRCH policy that staff should report all incidents clinical and non-clinical, causing actual or possible injury, patient dissatisfaction or property loss or damage. On average five incidents a month were reported. It is nationally recognised that an organisation that reports a higher number of incidents is safer than those with a lower reporting culture. We noted that the CCG had commented on the low level of reporting and that the trust was working on improving incidents, including incidents that did not affect patients.
- The incident log reflected a narrow range of incidents and the number of incidents was lower than expected for a 24-hour service with this number of patient. We noted that staff did not use the incident reporting system to record staff shortages, times when the escalation policy was used, when fractures were missed or medication incidents. Staff we spoke with said they sometimes mentioned incidents to a colleague but did not record them because of lack of time. Doctors did not appear to record incidents. The effect of low reporting was that managers did not have a clear picture in one place of the spread of incidents in the UCC.
- Some deaths had occurred in patients seen and discharged by the UCC. We reviewed the root cause analyses (RCA) of three serious incidents (SIs) reported. Two other SIs had occurred more recently, but the RCAs were not yet available.
- There had been delays in the submission of two SIs. One SI was reported in January 2015. This was investigated by Greenbrook with support from HRCH and the report was submitted to the CCG within timescales. However the HRCH medical director and commissioners had concerns about the quality and completeness of the report and the CCG requested an external review of the incident. This had not been received by the CCG at the time of the CQC inspection, and was not made available to the trust until June 2016. Since the inspection we saw that, on receipt of the report, the trust immediately built on action already taken in response to the recommendations. An action plan would be completed by Sept 2016.
- The second SI was reported in October 2015. HRCH requested an external review of this report as it was the second SI which related to the death of a child under one year old. There were questions regarding the quality of this report and so there were considerable delays before this was submitted to the CCG. Immediate actions were taken to address the emerging themes.
- The Medical Director of HRCH oversaw the investigations and was responsible for signing off the final reports. The views of Greenbrook Healthcare staff or locums were incorporated into the investigation and the final report was shared with all parties. The principle

of sharing was to ensure that staff could be made aware of action plans and learning from the incident. Some staff we spoke with were not aware of serious incidents that had taken place at the UCC.

- The Medical Director of HCRH had reviewed themes from SIs in the UCC and recorded them as a risk on the risk register.
- We did not see evidence that learning from incidents was discussed widely with nurses and doctors to ensure system wide learning. Discussion of incidents seemed to be mainly with staff immediately involved.
- We were told that UCC incidents were discussed and decisions made to close them, at clinical governance meetings which was evidenced by the minutes of those meetings.
- A recent copy of those minutes recorded that the clinical director of Greenbrook had circulated advice on what to class as an incident. Staff we asked about this at our inspection were not yet aware of any drive to improve incident reporting. However, after the inspection we saw an action plan to improve incident reporting.

Duty of Candour

- The duty of candour requires senior staff to tell patients and their families about safety incidents that affect them, give an appropriate apology, keep them informed about investigations, and support them to deal with the consequences. Nurses at both centres were unsure about the implications of the duty of candour, although they were aware of the principles of openness. They had not received training on duty of candour. However, we saw evidence of duty of candour processes by managers following a complaint. Senior staff offered to meet the patient and family for open discussion in addition to writing a letter.

Safeguarding

- The trust's Safeguarding Children Policy and Protecting Adults at Risk internal procedure were available on the Trust intranet along with clear procedures for staff to follow regarding child protection and adult safeguarding. Contact details of the relevant local authority safeguarding leads were on display in the offices and in the nurses' stations.
- Staff received role specific safeguarding training either to Level 2 or to Level 3 and were up to date. They had access to current guidance through the trust intranet. Level 3 training was run by the local authority.
- Staff knew how to recognise signs of abuse in older people, vulnerable adults and children, and how to share information about safeguarding concerns.
- A chaperone policy made it clear that staff should have a chaperone present before they carried out any intimate examination. Nurses performed chaperone duties.
- The trust required staff to record all safeguarding concerns on the electronic reporting system. We also saw guidance on recognising a vulnerable adult (produced by Greenbrook) in the nurses' station at the UCC.
- At the UCC, a liaison health visitor, employed by HRCH, was present on weekdays. The role included checking child attendances against the child protection register and making inter-agency referrals where there were safeguarding concerns. This was a new post and there was no cover at weekends. The trust told us that safeguarding concerns were raised on the electronic incident reporting system that would alert the HRCH safeguarding team. We saw a safeguarding referral made through the liaison health visitor based at the UCC.
- The computer system flagged patients already on the child protection register. This helped staff to meet their needs appropriately. Standards for Children and Young People in Emergency Care Settings 2012, says that "all unscheduled care attendances by children shall be notified to that child's primary care team: ideally both the GP and the health visitor or school nurse". We saw that the UCC sent information to the GP and were informed that the paediatric liaison health visitor reviewed all UCC attendances of children and shared these with the community health visitor or school nurse.

Medicines

- Medicines were stored securely at the walk-in centre and UCC, and were only accessible to authorised staff. We saw processes to ensure that medicines were within their expiry date and all the medicines we checked were in date.
- We reviewed the medicines management report for February 2016 that included audit results and actions where appropriate.

Requires improvement

Are services safe?

- Staff monitored fridge temperatures. We saw there had been an issue in the past about consistent recording at the walk-in centre but new processes had been put in place.
- Some nurses at the walk-in centre were qualified to prescribe. Other nurses, ECPs and agency nurses could not prescribe but could use patient group directions (PGDs) that we checked and found up to date. The lead nurse for the UCC was an independent nurse prescriber and other nurses used PGDs.
- GPs at the walk-in centre prescribed medicines for patients in line with the agreed Formulary, local prescribing guidelines and in compliance with HRCH Medicines Policy.
- Staff had access to the antimicrobial guidelines and trust formulary. In line with HRCH policy quarterly antibiotic audits were carried out to assess adherence to local antimicrobial prescribing guidelines. At the walk-in centre 96% of medicines prescribed followed the trust guidelines (this was better than the overall trust target of 90%).
- At each centre we found one old British National Formulary (Guidance on the selection and clinical use of medicines) in a clinic room (dated March 2015), but saw that staff had access to the latest electronic copy on their workstations or phone (via an app).
- Medicines at the walk-in centre were provided under a contract with a pharmacy based in the hospital, although this was about to change as that pharmacy was closing. Arrangements had been made with another pharmacy nearby. The WMUH pharmacy department supplied medicines to the UCC. We saw evidence of appropriate requisition forms, stocktakes, and signatures for delivery, as well as checks that were carried out on the expiry dates of medicines. We saw that medicines were disposed of in an appropriate pharmaceutical waste bin and there were records of collection by the contractor. A pharmacist visited the UCC once a week. This pharmacist was also involved in multi-disciplinary meetings and in training staff on the safe use and handling of medicines.
- At both centres, prescriptions were only available to authorised staff. There were two ways that medicines were prescribed. Prescriptions could be printed directly from the patient information management system. If that system was unavailable FP10 prescription forms were also kept on site. Both the S1 prescription sheets and the FP10 prescription pads were kept securely.
- At the UCC, although the medicines cupboards within the clinic room were not locked, the room itself had restricted access control and was only accessible to clinicians. Staff monitored fridge and room temperatures daily and they were within the correct range. The risk register showed the temperature of the drug store room occasionally rose above 25ºC. Staff mitigated this through using fans. Staff knew what to do if there was a break in the cold chain.
- Antibiotic audits over the past year at the UCC showed that by the end of the year the centre had progressed from 67% compliance to 88% of antibiotics being prescribed in line with the trust guidelines. However, these were below the target 90% adherence to the guidelines.In 31% of cases prescribers were not providing complete records of the quantity/duration of treatment.
- At the UCC, staff we spoke with knew how to recognise and report medicines safety related incidents, through the electronic reporting system. However, no medication incidents had been reported recently. When we asked further about this, the clinical lead GP showed us evidence of learning that had been disseminated to other staff members about medicines management (e.g. when a medicine that had been prescribed off-formulary). However, no incident report had been made, contrary to good practice, and HRCH policy.

Environment and equipment

- The walk-in centre and the UCC were well maintained.
- Basic resuscitation equipment at the walk-in centre was available to treat complications of routine care. This included an anaphylaxis kit (to manage allergic reactions), oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff told us they would check the trolley immediately after any equipment was used, or the first week of every other month. The trolley was not locked so there was a risk that items might be removed before the next check. The checklist did not detail the items, for example the checklist said 'anaphylaxis kit' rather than listing the components of the kit. The trolley also contained asthma medications that were presumably for use in the room in which the trolley was kept. There was an out of date bag valve mask.
- An automated external defibrillator, AED, (used to attempt to restart a person's heart in an emergency) was available at the walk-in centre. We were told this was

also for use elsewhere in the hospital in the event of a patient, visitor, or member of staff collapsing. The large oxygen cylinder would not be easy to transport in an emergency. The suction was mounted on the wall so might also be forgotten in an emergency. However the HRCH policy was to call 999 and await emergency services. The equipment would be used while awaiting an ambulance.

- At the UCC resuscitation equipment was available, including an AED and oxygen. Records for the past two months showed the equipment had been checked daily. We noted that there were not always nurses on duty in the UCC who were trained in intermediate life support (ILS) of intermediate paediatric life support (IPLS). However, all nurses were trained in basic life support, including paediatric life support, in line with the College of Emergency Medicine's minimum requirements for unscheduled care facilities (July 2009). There was an agreed pathway with the co-located ED; a resuscitation call would be made via the hospital system and the hospital resuscitation team would attend. Hospital staff would then take on advanced resuscitation as the patient would immediately become an ED patient. As the unit assessed a wide range of walk-in patients for emergency care we fe felt the issue was more about the skills to recognise the signs of deterioration quickly enough to avert an incident, rather than resuscitation skills.
- In both units staff told us they had the equipment they needed to carry out diagnostic investigations, assessments, and treatments. Portable electrical equipment had been routinely tested and serviced. Fire equipment had been tested regularly.
- On 11 March 2016, there were no signatures to indicate that the sluice room had been checked in the preceding four days. However, the room was clean so the absence of a signature may have been an oversight.
- The UCC had spacious treatment accommodation with large doctor's consultation rooms and three streaming rooms that were underused. There was scope to use the accommodation more efficiently.

Quality of records

- Both services used the same computer system as the trust.
- In Hounslow the computer system was compatible with the system used by all GPs. This enabled staff, if necessary to check patient's history. Staff recorded treatment details electronically at the time or shortly after treatment. The information was shared with the GP in real time. For out of borough GPs that used different systems, staff faxed details to the receiving GP by 8am the next day. This meant that GPs were aware of the need for any further action, so they could resume care for the patient where necessary.
- We noted that incident reports had revealed instances where patient notes by UCC clinicians had not been recorded in enough detail. We were told that action had been taken in relation to specific individuals to improve practice. We reviewed a sample of records on inspection at each site and the level of information was adequate.
- Richmond GPs used a variety of patient information systems so communication from the walk-in centre was necessarily less streamlined than in Hounslow.

Cleanliness, infection control and hygiene

- The walk-in centre and the UCC were visibly clean and tidy. An infection control policy was available on the intranet for staff to reference.
- Staff had access to hand washing facilities and sanitising gel prior to patient contact. Notices about hand hygiene were on display near washbasins. We saw good hand hygiene and IPC practice in the consultations we observed. However, audits showed that hand hygiene at the UCC been lower in the last months of 2015 (50% compliance with hand washing before and after seeing a patient, and compliance with good technique). The most recent audit in January 2016 showed an improved score of 85% but this this was below the expected 100% target. During our inspection, we saw good hand hygiene and Infection Prevention and Control (IPC) practices. The trust had moved from self assessment of hand hygiene to using an external observer and trainer to improve hand hygiene standards.
- Hand sanitisers were visible in the waiting area for patients and families. In the UCC, there were no notices encouraging patients and families to clean their hands and we did not see patients or families doing this.
- Personal protective equipment such as disposable aprons and gloves were available and used appropriately. Staff we spoke with said they had had training in infection control as part of mandatory training. Staff complied with 'bare below the elbow' policy for best hygiene practice.
- Clinical waste was stored securely. Sharps bins were appropriately labelled.

Requires improvement

Are services safe?

- We saw cleaning schedules. A cleaner was available to the UCC all day. This service was provided by the hospital. Healthcare assistants cleaned clinical equipment.

Mandatory training

- Compliance with mandatory training was 73% at the walk-in centre and 78% at the UCC compared to a trust target of 85%. The smaller number of staff at the walk-in centre meant that one staff member not completing training could make a disproportionate different to the score.
- At the walk-in centre, managers held regular training days so staff could access much of their training at set times. Nurses had protected time in their rotas to undertake training. Most training other than resuscitation training was online.
- The basic life support course used was Resus Level 3 - Medical Emergencies and Resuscitation Course (Extended) which included use of automatic emergency defibrillating equipment (AED).
- A registered paediatric nurse worked at the walk-in centre three days a week. Managers were planning to increase cover to seven days a week. Paediatric refresher sessions competences were not part of mandatory nurse training.
- At the UCC we reviewed Greenbrook's competency assessment handbook for Emergency Nurse Practitioners, Advanced Nurse Practitioners, and Emergency Care Practitioners. We were informed that core paediatric competencies for children aged over 2 years were within the basic ENP and ECP training; children under 2 years were seen by GPs. This arrangement therefore met the contractual requirements. In addition, the lead nurse had undertaken a module on the assessment of the unwell child as one of her core modules allowing her to treat children with minor illnesses. Nurses had attended refresher sessions on the assessment of children in 2016.
- All staff at HRCH had statutory and mandatory training on risk management and incident reporting once every three years.

Assessing and responding to patient risk

- At the walk-in centre, patients booked in at reception. Reception staff recorded, electronically, their details and their reason for attending. Nurses in the nurses' hub could see this information on a screen. Nurses could also observe patients in the waiting area by CCTV from the nurses' station. The screen and the ability to scan the waiting room enabled them to identify any patient that needed speedier assessment.
- When the unit was not too busy, nurses carried out an assessment in a triage room. At busy times the nurse carrying out the initial assessment approached patients in the waiting area to ask how they were feeling and if they would like pain relief; this approach did not protect the privacy and confidentiality of patients.
- The target to assess patients within 15 minutes was one of the Key Performance Indicators for the walk-in centre. The unit was meeting this in 89% of cases. Another performance indicator for this centre was the time to treatment, which was set at under 60 minutes on the basis that prompt treatment provided the best experience and outcomes for patients. The unit met this target in 41% of cases on average in the past year.
- An escalation process was in place for patients attending who were seriously unwell and needed treating elsewhere. The clinician assessed the patient to decide on the appropriate referral pathway. We observed a patient transferred by ambulance to an acute hospital and saw another patient referred to ED and given directions about how to get there. Staff told us that they had discretion to send a patient to ED by taxi, and had a small budget to cover this. In transfer cases nurses gave the patient a letter to take to ED explaining the reason for referral, which staff also explained to the patient. 2613 patients had been referred to ED since April 2015. This was safe practice.
- At the UCC a number of the walk-in patients would need emergency hospital care. The reception desk was the gateway to both A&E and urgent care. Patients arriving at the UCC booked in with a receptionist. There were two receptionists during the busiest times of day or evening. Patients then awaited initial assessment by a clinician (band 6 or 7). The purpose of the initial assessment by the streamer was to identify whether staff should pass a patient immediately to ED or a speciality doctor (prioritised as category 1).
- The process of assessing a patient through a glass screen, while the patient was standing in a public area was not ideal. The streamer asked for a very brief history of the presenting complaint and about pain. Depending on the condition, the nurse might measure the patient's temperature, pulse rate, and the level of oxygen in the

blood and sometimes their respiratory rate. They recorded the results electronically. The streamer prioritised UCC patients on a scale of 2-5, with two being those needing treatment most quickly.

- A patient meeting the criteria for immediate access to ED was given a paper to present to ED reception, at the far end of the waiting room. These criteria included high-risk patients such babies under 28 days old, patients undergoing chemotherapy, children on the child protection register, GP referrals to a speciality doctor, patients with chest pain, patients with strong evidence of psychosis or significant self-harm, or children under 16 with mental health difficulties.
- Within the treatment area, clinicians could see a list of patients requiring follow up assessment and treatment after initial streaming on a display screen in the nurses' station, or via a computer in consulting rooms (anonymised so other patients in ED could not see the details). This showed the patient's condition, and how long they were waiting. The waiting times to treatment after streaming could be long.
- The streamer used a 'red flag' system against which certain levels of systolic blood pressure, heart rate, respiratory rate and oxygen saturations indicated that staff should take prompt action.
- There was an escalation procedure for when the number of patients waiting prevented staff meeting targets for treating and discharging patients. However, staff did not record use of this procedure as an incident.
- At the UCC not all children had been assessed promptly in the year to January 2016. However, more recent data provided by the trust showed that performance had steadily improved and in June 96% were streamed within 15 minutes, although this was below the CCG target of 98%.
- At the UCC, audits of medical practice were carried out by the contractor providing medical cover at the UCC. For example, the lead GP audited five sets of patient notes a month for accuracy. As we had seen that some serious incidents had revealed concerns about accuracy of clinical records, the need for a full set of clinical observations and thorough history there might have been a case for increasing the proportion of notes audited to explore record keeping standards more fully. An audit of streaming (January 2016) indicated that staff did not always record a full set of baseline observations for relevant patients at streaming. This strengthened the case for more emphasis on the completeness of record keeping by nursing and medical staff.

Staffing levels

Walk-in centre

- The staffing establishment of the walk-in centre was 15.81 WTE staff, including emergency nurse practitioners (ENP), emergency care practitioners (ECP) and health care assistants. Many staff worked part time. On the day of our inspection there was one band 7 nurse vacancy (0.78) which was 5% of the staffing establishment. Agency and bank staff were occasionally used to cover staffing gaps caused by sickness, absence or vacancies but usage was low.
- The staffing varied according to the time of day and the day of the week to meet demand. For example, on the day we inspected were three nurse practitioners and a healthcare assistant until 8pm. After 8pm, there were two nurses until the unit closed. This aligned with normal attendance patterns. The busiest days were the weekends, followed by Mondays and Tuesdays. Mornings were busier than afternoons.
- Most staff had worked at the unit for some years and were very experienced.
- A registered paediatric nurse worked three days a week. Among existing nursing staff at the walk-in centre all nurses were qualified under general nurse training which included paediatric training. Five nurses had done additional modules in paediatric training e.g. childhood asthma.
- When there was no paediatric nurse and no GP, the unit did not generally treat children under two years old.
- Nurses told us that demand was not always predicable and some evenings there were a higher number of patients than they could treat before they closed. If this happened, the Demand and Capacity policy was implemented and reception staff would explain this to patients attending the WiC. This meant that nurses would assess every patient who came in, give self-care advice, or refer patients to an emergency department. The incident report showed occasions when procedure was used. These events were on the risk register because of the risk that a patient might have a more serious condition than the initial assessment suggested, and HCRH could be considered legally liable until they were treated elsewhere.

Requires improvement

Are services safe?

- GPs provided 62 hours cover a week through a community interest organisation of local GPs with which the trust had a service level agreement. There were 30 GPs involved in this group. Nursing staff confirmed that there was a regular pool of doctors who worked at the centre and were familiar with processes.
- GPs in the centre saw an average of four patients an hour.
- One GP was present on weekday evenings from 6.30 until 10pm. Two GPs worked from 8am until 6.30pm at weekends and bank holidays, and one worked until 9pm those days. The CIC was responsible for providing GP cover when a GP was absent. The company employing the doctors had its own medical director and clinical lead.
- GPs were required to comply with HCRH clinical governance requirements, and take part, where appropriate in clinical audit, review of outcomes and mandatory training. The lead clinician was responsible for the induction of any new GPs and for ensuring that all GPs undertook mandatory training as required. The lead GP gave feedback to GPs after their first shift, and signed off their competences,
- HRCH staff agreed the requirement for checking GP's credentials and competences.

UCC

- The nurse establishment was 33.25 whole time equivalent (WTE) staff. This included a buffer of 2.32 WTE staff for ad hoc emergency shifts. The vacancy rate was 19% in February 2016. Three staff were on long-term sick leave. There were 19 permanent nursing staff, employed by HRCH. listed on the training register. Agency staff covered sickness and other absence. The average fill rate for shifts was 98%.
- UCC managers were authorised to arrange agency nursing staff. In the event of a gap, they would first ask permanent staff if they could cover extra shifts. The CCG required the use of specific agencies. However, the UCC staff said they sometimes had to use other agencies when those on the CCG list could not provide short notice staff. Greenbrook was developing its own 'not for profit' nursing bank.
- Emergency Nurse Practitioners (ENP) and Emergency Care Practitioners (ECP) worked 12-hour shifts with staggered starts. There were normally at least two ENPs on duty. At night, there was only one registered nurse or practitioner. Nurses treated 35% of patients on average.
- The lead nurse had paediatric training and was the on-site lead for safeguarding. All nurses had training in basic paediatric competences, however, there was not necessarily a nurse with appropriate training in managing children on every shift, which was contrary to the Standards for Children and Young People in Emergency Care Settings 2012. Clinicians assessing and treating children need adequate training, either the Royal College of Nursing paediatric competencies or equivalent.
- Nurses undertook streaming for up to four hours in the day and for longer periods at night. Streaming nurses aimed to assess 20 patients an hour.
- Medical cover was by seven salaried GPs and 11 GPs employed on service agreements with Greenbrook (the agreements meant either party had to give three months' notice). There was stable clinical leadership.
- Rotas were developed three months in advance. Other shifts were filled with bank doctors from Greenbrook's own bank, or locums from agencies. There were high numbers of locum doctors: 92 different doctors had worked at the UCC since September 2015. Locum doctors and agency nurses signed a standard induction checklist to show that they understood key UCC processes, including safeguarding. Temporary staff also had access to a short booklet about working in the UCC.
- Although the average fill rate of GPs was high, (99%) there had been individual shifts with greater shortfalls and patient waiting times then suffered. Staff said they spend a lot of administrative time ensuring shifts were filled. There was no cap on locum rates of pay, so the use of locum doctors caused a financial pressure.
- The doctors' start times were staggered so that there were more doctors on duty at the busiest periods. During the day, there were at least three doctors on duty. There was one doctor from 1am to 8am. Shifts varied in length. There was no formal handover in the UCC so doctors used a communication book and shift leaders log for communication.
- At night, there were only two staff on duty. This met the requirements of the minimum staffing provision of the standard for unscheduled care facilities. If one health professional went sick, there was an arrangement for the service to move to an area within the hospital ED to avoid lone working.
- Doctors treated 65% of patients attending the UCC. On average they assessed and treated 2.5 patients an hour.

Requires improvement

Are services safe?

- We were told that doctors streamed patients when the case mix caused nurses to be busier than doctors, but we did not observe this happening.
- During February and March 2016, the HRCH had funded the UCC to increase the medical and nursing cover in response to the higher number of attendances common in the winter months.

Monitoring safety and responding to risk

- Both the walk-in centre and the UCC had systems and policies to manage and monitor risks to patients, staff, and visitors. There was a lone working policy and policies for staff on dealing with difficult behaviour.
- In addition to the overarching trust risk register both centres had their own risk registers. We reviewed both risk registers and saw they were up to date.
- There was a security risk to staff in the walk-in centre because members of the public could enter the clinical area through an unlocked a side door. This was on the risk register. A security guard was present in the building 24 hours a day, manning the front entrance and undertaking rounds day and night. They said incidents were very rare and none had been serious.
- The lead nurse was aware of the risks within their service and other staff we spoke with also understood the risks and mitigations relevant to their area of work At the UCC staff were not all clear about the risks relevant to their area of work and actions being taken to address them.
- The hospital provided security guards throughout the day and night. Reception staff called security to help deal with patients with difficult behaviour. A security guard said reception staff called security at least once every night. The security service also patrolled the UCC six times a night.

Major incident awareness and training

- HRCH had arrangements to manage emergencies appropriate to a walk-in centre and an urgent care centre. All staff knew the location of emergency equipment.
- There was a business continuity plan, reviewed every two years, to try to ensure a specified minimum level of service within the first hour of the disruptive event occurring. There were action cards on the premises showing staff roles following a disruptive event.
- HRCH were members of Kingston, Richmond, and Hounslow systems resilience groups (local groups to increase the capacity of primary care, particularly out of hours). The UCC provided the main out of hours urgent care capacity.
- In the event of a major incident in Hounslow, UCC staff told us they would follow directions from the hospital emergency department.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated the urgent care services overall as good for effectiveness because:

- Patients were treated in line with national guidelines.
- Most patients received prompt pain relief.
- The trust had oversight of the revalidation status of doctors employed by the sub-contractors.
- The walk-in centre had a regular programme of local audits appropriate to the size and type of service such as dressings and staff productivity.
- The local audit programme for the UCC for 2015/16 showed 13 clinical audits. These included the appropriateness of referrals, the 'miss' rate of x-rays and asthma care.
- Information was passed promptly to GPs after treatment and for children, to health visitors.

However

- There was no clear system at the UCC for disseminating learning from audits to all staff to improve practice, although action was followed up with individuals and a report was produced at the end of the audit.

Evidence based care and treatment

- Trust wide, evidence based practice guidance was available on the HRCH trust intranet. This included national standards on Feverish illness in children, Urinary tract infections in children and adults, and diarrhoea and vomiting in children under five years old.
- GPs and nursing staff we spoke to could clearly outline the reasons for their approaches to treatment. They were familiar with best practice guidance from the National Institute for Health and Care Excellence (NICE). We reviewed a sample of patient notes at each centre that corroborated this.
- Staff were well supported in providing care and we saw staff asking others for second opinions if the colleague had specific expertise.
- Although most treatment guidelines were produced by HRCH, at the UCC we saw guidance produced by Greenbrook, for example a chaperone policy, alcohol guidelines and the management of fracture guidelines.
- In both centres children under two were assessed by a doctor because these children were a recognised vulnerable group whose health can change quickly. The target was to assess all children within 15 minutes. From the data available on inspection it appeared that on average a third of children under two at the UCC waited over 15 minutes over the six months to January 2016. We were subsequently told that this was partly due to an IT problem. However, recent data showed that 96% of children were being streamed in 15 minutes by June 2016. Where possible, if the centre was not too busy the child was assessed and treated immediately. However we did not see examples of this during our inspection.
- As there was no doctor at the walk-in centre during the day appropriate children were assessed by a nurse and referred to a GP or ED as necessary.
- The UCC streamer referred any adult patients reporting mild chest pain (below the threshold for referral to ED) for an electrocardiogram (ECG). ECG is the simplest and most important tool for identifying the risk of a heart problem. The target time for a person to have an ECG was 15 minutes. A consultation with a doctor should follow this within 20 minutes. We asked whether this process was audited but staff were not sure.

Pain relief

- At both centres, the initial assessment nurse asked about levels of pain and provided pain relief, if required through a prescription or PGD. This meant that patients obtained pain relief promptly.

Patient outcomes

- There is no national benchmarking for urgent care, and no national audits to which urgent care facilities routinely contribute. HRCH had an annual audit programme for all services that included hand hygiene compliance and infection control procedures as well as clinical practice, and medication audits. Trust policy was that each service should undertake at least two service improvement projects a year, over and above any trust wide audit requirement. At least one of these was expected to be a re-audit of a previous project.

Good

Are services effective?

- Nurses at the walk-in centre had concerns about the clarity of some x-ray images, and were keeping a log of incidents. X-rays were relayed electronically to the radiology department at WMUH. Nurses said they could contact the hospital department if they were unclear about what an X-ray showed. A radiologist at WMUH emphasised the importance of tight quality control as errors were often due to the operator rather than the age of equipment.
- The audit of streaming to ED in December 2015, revealed about 20% of cases sampled were inappropriately referred to the ED department and could have been seen and treated in the UCC. The main part of the action plan was feeding back to individual staff. There was no mention of wider staff training and discussion to reinforce ways to change this.
- The shift lead reviewed all x-rays within 24 hours to identify any discrepancies and patients were recalled as necessary.
- At the UCC there was some duplication of effort as all patients were seen by two clinicians and we saw a number of examples where a patient was seen by more than two.
- Late referrals to ED were also a risk to patients and resulted in a poor patient experience. The had a consequential impact on the hospital ED targets for treating patients within target times.

Competent staff

- Nurses we spoke with at both centres told us they had quarterly clinical supervision in line with the trust policy, however, we were aware from a supervision audit that the trust target of 85% by December 2015 was not fully met. However, the trust target of 85% uptake of clinical supervision was exceeded in February 2016 (Board performance scorecard) at 88%. Urgent care services achieved 93% uptake.
- All nurses should have annual appraisals that identified learning needs. Urgent care services achieved 84% against a target of 85%.
- ENPs and ECPs were required to have Red Dot training (X-ray interpretation for minor injuries) and Ionising Radiation (Medical Exposure) Regulations Training (about the risks of X-rays).
- Staff had not had specific training on Dementia awareness, however some nurses said they had experience of some patients with dementia and were used to communicating with carers and relatives. They prioritised the assessment of such patients. Staff had received training in equality and diversity.
- HRCH management kept details of the timing of GP's revalidation at the walk-in centre. (Every GP is appraised annually and undertakes a fuller assessment, known as revalidation, every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). Where there were concerns the UCC and/or the trust would relay these to the relevant NHS England Responsible Officer.
- There was a case for reviewing paediatric competences and providing opportunities for updates among UCC staff, particularly as there had been serious incidents relating to the diagnosis in children in the recent past.
- Fully trained staff can work autonomously in urgent care settings. Other clinicians need access to advice. Records showed that doctors on the GP vocational training scheme (VTS) had not always had sufficient supervision, but on our inspection we saw that processes had changed to rectify this.
- Reception staff at the UCC had regular conflict resolution training which they said they found helpful in dealing with aggressive patients or family members.
- The contractors that provided doctors at each centre supplied HRCH with details of GP responsible officers, appraisals, and revalidation dates. (Every GP has an appraisal each year and undertakes a fuller assessment, called revalidation, every five years. Only when revalidation is confirmed can the doctor continue to practice and remain on the performers list with NHS England). HRCH confirmed that no doctors' registrations had expired. However, the trust had no systems to input into the revalidation process even though the doctors were working on behalf of the trust.

Multi-disciplinary working and coordinated care pathways

- Staff or their managers at the walk-in centre had links with the ambulance service, health visitors, social services, the emergency departments of Kingston and West Middlesex Hospitals, and the Richmond Re-ablement service.
- Walk-in centre staff could make direct referrals to local services including GPs, for example for non-urgent blood tests, falls clinics, and physiotherapy in line with

good practice. The number of referrals to GP practices made since April 2015 was 714. Nurses felt it would be useful to have closer links with GP practices to prevent inappropriate referrals to the centre, for example as a short cut for getting an X-ray for which GPs should use the outpatient referral system. Nurses were only authorised to request X-ray for recent fractures.

- The UCC's links with the local health community were mainly through GPs. Staff could redirect patients to GPs and sometimes make GP appointments for patients living within the Hounslow area. They could not do this for patients from other boroughs. UCC clinicians did not directly refer patients to other community services.
- UCC staff had links with the emergency department of the hospital on the same site. Hospital and UCC staff said that they could sort out issues face-to-face. However, two ED clinicians we spoke with said UCC clinicians transferring a patient to ED did not always provide enough information. There was no information sharing protocol. In addition, the UCC computer system was not able to interface with the ED computer system, so when the UCC transferred patients staff had to print paper copies of the patient record for ED to record manually.
- UCC clinicians had access to x-ray through the radiology department at WMUH. This was for suspected limb fractures only. If a clinician considered that a chest x-ray was indicated, they referred the patient to ED.
- Clinicians at both centres could refer patients with simple fractures for follow up at the WMUH virtual fracture clinic. At that clinic, a consultant reviewed x-rays and the patient received the results by telephone. In many cases, patients did not need to be seen face to face. The patient's GP could later arrange physiotherapy if required.
- A few patients with mental health problems attended the UCC. When they did so, staff sought specialist mental health input from the West Middlesex Psychiatric Liaison team that served WMUH.
- UCC managers said they networked with other urgent care centres managed by the same contractor, but they had no links with the HRCH walk-in centre in Teddington.

Referral, transfer, discharge and transition

- Medical records of patients registered with a Hounslow GP were available to UCC clinicians through the electronic health records system. This helped them to check the patient history or medication used, where relevant. At the walk-in centre clinicians did not necessarily have more than summary information because GPs used a range of different patient record systems.
- Discharge information was sent electronically to patients GPs where possible. Reception staff faxed hard copy to GP practices that did not have access to the same electronic system.
- At neither centre did patients receive written information on discharge, which is good practice,

Access to information

- Trust wide, evidence-based practice was available on the HRCH trust intranet. This included national standards on Feverish Illness in children, urinary tract infections in children, and adults, diarrhoea and vomiting in children under 5. Staff said their managers updated them when policies changed. Guidelines and policies were on the HRCH Trust intranet. When there were changes Trust policy was for managers to brief staff on the contents and what this meant for staff, and staff we spoke with confirmed that they received updates,
- At the UCC, managers told us there was a 'daily huddle', an opportunity for quick information sharing in the centre at 3pm daily, at least for staff on duty at that time.. However, this did not take place during our inspection because staff were too busy

Consent

- We saw staff asking for verbal consent from patients before examination and treatment.
- Staff were aware of the Gillick competency principles which relate to gaining consent from children under 16 (The Gillick test is used to assess whether children under 16 are mature enough to make their own decisions and understand the implications of the decision.)
- When staff referred patients for x-ray they advised the patient of the known risks (although small) of unnecessary exposure to radiation.
- Staff had access to guidelines for dealing with patients with learning difficulties or living with dementia.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- We observed staff treating both children and adult patients with kindness, and in a professional way .
- Patients and relatives we spoke to were satisfied that staff had treated them with compassion and helped them understand their condition.
- We saw that staff respected patients' choices.

However,

- Privacy of patients when carrying out initial assessments at busy times was not always considered.
- Responses to the Friends and Family test, from fewer than 5% of attendees, did not provide a wholly reliable measure of the satisfaction of patients attending.

Compassionate care

- We saw nurses treating patients and their relatives kindly and with respect in consultations in both centres. They provided treatment in a professional way, sensitive to the individual's needs.
- The Friends and Family Test (FFT) is a method used to gauge patient's perception of the care they have received. Patients who completed the survey reported they would be likely or very likely to recommend the UCC to their friends and family. Since November the walk-in centre had achieved a response rate averaging 8%, and 93% of patients said they were likely to recommend the service. Some caution is needed in interpreting the results of this modest sample. At the UCC, 99.3% of patients would recommend the service to their friends and family, and 78% would be extremely likely to do so. The centre displayed cards saying 'How are we doing' inviting patients and families or carers to give feedback. Although there was a terminal in the treatment area where patient could answer the questions electronically it was not placed in an area that most patients would notice. There was no terminal in the waiting room. We did not see staff actively encouraging feedback from patients and families. The average response rate in the three months to January 2016 was only 4% which means this information alone is below national expectations and too low to provide a firm basis for making judgements about quality. A survey had been commissioned to provide more in depth data.
- Patients at the walk-in centre completed CQC comment cards to provide us with feedback, 87% of patients were very positive about the service. Examples of comments were: "I felt the environment was exceedingly safe and hygienic"; "Patient Care has always been excellent - the small touches like a nurse coming out to advise on waiting times and to check if comfortable are fantastic". Staff took pride in their friendly service. They collected compliments through cards from patients, and Twitter. Patients had the support of volunteers from the League of Friends in welcoming patients and explaining where to go.

Understanding and involvement of patients and those close to them

- At the walk-in centre, we saw patients being given relevant verbal information and explanations about their care during consultations. For example we saw a nurse explain X-ray findings to a patient. We also saw staff checking patients or carers understanding of treatment provided and planned. Survey results indicated that the great majority of patients felt they had the care that was right for them and were involved in making decisions. The patient survey results confirmed this.
- Staff did not give patients written information to back up the verbal explanation they gave. We did not see leaflets available for patients,
- Many patients we spoke with did not know that the UCC was not provided by the hospital. In practice this did not matter unless they needed to make a complaint.

Emotional support

- We saw a nurse putting an anxious patient at their ease at the walk-in centre. At the UCC we saw another nurse reassuring a patient that a symptom would resolve on its own and did not need treatment.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

We considered the walk-in centre provided responsive services, but as the UCC services had a some areas requiring improvement, the services overall were judged to require improvement.

We judged the urgent care centre needed to improve its responsiveness to patients needs because;

- A number of patients, albeit a small percentage, waited over four hours from arrival to discharge.
- There was no information for patients and their families about waiting times unless they specifically asked.
- There was no child or family friendly waiting area or cubicle and not enough seating in the waiting area at busy times.
- Although there were private streaming rooms nurses did not often use these. Assessing patients from behind glass while patients stood in the public waiting area compromised patients' privacy and dignity.
- Adults had relatively long waiting times for this type of service, above the national target for urgent care.
- At neither centre did staff routinely give patients, or their parents and carers, written information about their condition and treatment and warning signs to be aware of, on discharge.

However at the WiC;

- Staff demonstrated good knowledge of the local and wider population and engaged with the CCG to make improvements over time.
- The centre was accessible to people who used a wheelchair, mobility aids and parents and carers with pushchairs, and there was a play space for young children..
- Information about the service was clearly displayed including on the HRCH website, including information about how to raise a concern.
- There was evidence that at the walk-in centre staff listened to patient views and adapted the service accordingly. They learned from complaints.
- The services were successful in keeping a number of patients out of the emergency service, although they both saw many patients with non-urgent conditions who should have seen their GP for medical care.
- There was support for patients not registered with a GP to be able to register

Planning and delivering services which meet people's needs

- Patients did not have to be registered with a GP to attend the centre. Overseas visitors were also able to attend for treatment.
- Both centres were accessible for patients with limited mobility. At the walk-in centre there was a low counter at reception so that people using a wheelchair could speak to staff easily. There was no such facility at the UCC. Staff had to come out into the waiting area to speak to people using wheelchairs and carry out the initial streaming assessment.
- There was access to interpreter services at both centres, by telephone, and staff were aware of these facilities. Staff at the walk-in centres said translation was not often needed. At the UCC staff reported that the main languages required were Polish, Latvian, Russian, and Asian languages.
- The receptionist gave patients an idea of waiting times, if asked, at both centres, but there was no display board indicating expected waiting times as these changed. On our unannounced inspection at the UCC waiting times had exceeded four hours for a short period. Neither centre displayed information about their performance across the standard clinical quality indicators to give the public a view of performance against national emergency service targets.
- Shorter waits for treatment will reduce patient discomfort. We noted some there had been a a significant increase in the number of patients waiting more than four hours in February 2016 compared with February 2015, with only a modest increase in patient numbers.
- The average waiting time for adults at the UCC was 1.5 hours in March 2016, an increase since April 2015 when it had been one hour seventeen minutes. The national target is a median wait of under 60 minutes.

Requires improvement

Are services responsive to people's needs?

- The WiC had a secure play space for young children. There was an accessible toilet and baby changing facilities. There was enough space for parents with buggies and prams.
- The waiting area at the UCC was also a waiting area for ED. Although one third of patients were children, there was no separate space for families and children, nor a safe children's play area. This was contrary to good practice recommendations that children should wait in areas audio-visually separated from adults, and that age appropriate activities should be available. The cubicles and consultation rooms were also not child friendly. On our unannounced inspection, two cubicles were being used for observing distressed young children. There were no toys or pictures to distract children.The design of the unit, and lack of provision for children was on the HRCH risk register. However we were told in July 2016 that designs have been signed off for a dedicated paediatric waiting room later in the year.
- At peak periods there were not enough seats in the UCC waiting area. We noted that a number of patients attended with several friends or family members. There were no signs suggesting that friends and family members might wait elsewhere until the patient was treated, or give up their seats to new patients coming in. Staff did not feel able to ask relatives and friends to offer their seats.
- Staff at the walk-in centre were aware of guidelines for managing patients with learning disabilities. A nurse gave an example of recently assessing and treating an autistic patient in the minibus they had been transported in, as the person felt more comfortable in familiar surroundings.
- Signs at reception in both centres encouraged queuing patients to stand back to prevent risk of overhearing conversations of the patient booking in. In the UCC the acoustics in the small room that accommodated receptionists and the streaming nurse were poor and patients had to speak loudly to be heard so other patients and staff could hear the conversation. The lack of privacy in streaming was on the trust risk register and graded as low, although we were told options were being considered to improve this. We considered this a significant risk to patient confidentiality and dignity. There was a similar, but lesser concern when the walk-in centre was busy and nurses asked people in the public waiting area about pain, but this affected fewer patients. The layout of the UCC with a reception at the front of the building, meant that some patients had to stand outside when there was long queue.
- On our unannounced inspection, we saw a nurse carrying out the initial assessment using one of the three streaming rooms at the UCC. This face-to-face assessment, although still quick, had the benefit of giving privacy to the patient and potentially allowing the patient to be more open about their health concern and help the nurse make a better assessment of their needs..
- Treatment was in consulting rooms or cubicles to ensure privacy. One consulting room in the walk-in centre had an oversize couch for patient examination.
- Managers recorded demographic data on the number and nature of attendances at both the walk-in centres and the UCC. At the walk-in centre attendances were spread across the age ranges: 5% of patients were over 75 years and 52% of all attendees were women. The majority of patients (72%) were white. The next largest group was Asian at 5%.
- At the UCC attendances were evenly split between male and female patients, of whom 44% were white. The next largest group was Asian, 23%. A small proportion of patients, only 2%, were over 75 years of age.
- Staff at the UCC had access to a suitable room for mental health patients while waiting for assessment. The same room could have other uses, for example if staff suspected a patient was infectious, or was in a lot of pain and did not want to sit in the waiting room.
- A yellow dotted line on the floor guided patients to x-ray in the main hospital ED, and then back to the UCC.
- Diagnostic tests offered at the UCC were urinalysis, ECG, and x-ray. UCC staff did not carry out blood tests, and this is with the agreement of the commissioners.

Access to the right care at the right time

- The walk-in centre was open every day from 8am to 10pm and until 9pm at weekends and bank holidays. The UCC was open every day of the year. There were no appointments. Nurses or doctors mainly saw patients in order of arrival unless a clinician assessed a patient to be unwell enough to be given priority.
- At the walk-in centre some services were only offered during certain hours, for example dressings were only offered until 6pm. The last patient for X-ray was seen at

6.45pm (4.45pm at the weekend). This falls short of the principles that services should be accessible, understandable and patient-centred, although staff said that in practice patients did not seem confused by this. However, there was a sometimes a challenge approaching closing time when there were more patients than the service could treat before it closed. A notice explaining this was displayed in the waiting area on those occasions and patients were given advice about whether to return next day or go to an emergency department.

- The walk-in centre aimed to see all patients within 15 minutes. The centre aimed to assess all children under two within 15 minutes of arrival, and all children under 18. The target for assessing adults was within 20 minutes. The target was met in 89% of cases. Although a few patients criticised waiting times, our observation was that waiting times were shorter than in many centres. About 41% of patients were treated in less than an hour from their arrival and most others within two hours. We saw that 99.9% of patients had been treated and discharged within four hours over the past year. Only 28 patients had waited over 4 hours between April 2015 and January 2016.
- The UCC target (set by the CCG) from the patient's arrival to their initial assessment was 20 minutes for adult patients. That was achieved in 96% of cases. The standard target for assessment in urgent care services is 15 minutes, and staff we spoke with were unsure why the UCC had 20 minutes for assessing adults. This delay was a risk in a service that received undifferentiated UCC/ED patients, a few of whom might be seriously unwell.
- The percentage of patients who left the department before being seen is often seen as an indicator that patients are dissatisfied with the length of time they have to wait. Nationally 2.8% patients leave without being seen for treatment. About 3% of patients left the walk-in centre without being seen. The local target was under 5% so the centre was performing within target.
- The number of patients making an unscheduled return with the same condition within 72 hours was below than the England standard. Five per cent of patients re-attended within 48 hours and 9% within 7 days. Staff considered that re-attendance was patient choice because it was easier than making a GP appointment.
- The walk-in centre transferred about 6% of patients to ED, or 260 people a month. This was because walk-in centres are not designed for treating long-term conditions or immediately life-threatening problems and could not treat head injury, chest pain, and possible stroke symptoms. If following assessment a patient was found to have breathing difficulties, severe abdominal pain or suspected of having a DVT (blood clot) nurses would refer them to a more appropriate service.
- During early 2015, there had been delays in getting an ambulance to attend quickly on the basis that the walk-in centre had a defibrillator so was able to respond to cardiac emergencies. Following successful discussions with the ambulance service there had been no recent delays.
- Between April 2015 and January 2016 2613 children under two had attended the walk-in centre. This was a large enough number for the CCG to fund a pilot of a paediatric nurse practitioner three days a week. We were later told that there was a plan to have a paediatric nurse practitioner every day, which would mean children under two could be treated for a wider range of ailments when there was no GP present.
- Part of the HCA role at the UCC was that of Patient Champion. This involved helping unregistered patients register with a GP and redirecting some patients to GP services. These staff were known as Patient Champions. On average 20 patients a month were registered with a GP , and 150 patients were re-directed to GP services in the six months from July 2015. In Hounslow, weekend GP hubs offered appointments between 10am and 4pm on Saturday and 10am and 3pm on Sunday. The UCC could make appointments for patients who ought to be seen by a GP rather than the UCC.
- Staff told us that the recently opened local GP Hubs providing care and treatment outside normal working hours had not affected the level of attendance at the walk-in centre because patients needed appointments to attend the hubs.

Learning from complaints and concerns

- HRCH policy for handling complaints and concerns was in line with national guidance, with a target of response within 25 days. Where urgent care service complaints required input from the GP service there were occasionally delays. This was on the risk register.

Requires improvement

Are services responsive to people's needs?

- Information on how to make a formal complaint was readily available to patients, clients and their relative and carers in leaflet form, on posters and on the HRCH website. Leaflets could be translated into different languages.
- There had only been 12 written complaints about each service in the past year so formal written complaints only came from a small proportion of attendees. However, reception staff and some nurses at the UCC said there were numerous informal complaints, mainly about waiting times. We observed some of these. Staff seemed defensive about verbal complaints and did not log them. This meant the overall complaint figures were artificially low, and we saw no system for learning from less formal complaints. No information about concerns and compliments, or trust response to complaints was on display for patients and visitors.
- Of the written complaints to the UCC only a quarter were upheld which seemed a low proportion and may have reflected a defensive attitude to complaints. The response to complaints was mainly in the form of direct feedback to the member of staff involved rather than wider team learning. Staff at the walk-in centre seemed more receptive to complaints and concerns. An example of change following a complaint at the walk-in centre was that a GP changed their practice on prescribing and documenting consultations with patients to include a far more detailed medical history, and a clearer documentation of allergy.
- At the time of the inspection there were five open clinical negligence claims related to care given by the UCC. Three claims related to medical care and were being managed by medical indemnity providers and two were being managed by the NHS Litigation Authority on behalf of HRCH.
- Staff said they were reviewing the issue of privacy on booking at reception because of complaints, and were investigating the option of installing privacy screens. Managers told us that the streaming nurse could ask a patient who did not wish to discuss their symptoms at the front desk to write down their symptoms or be taken to a private area to discuss these. We did not see this recorded as guidance for staff and we did not see clinical staff offering this. The alternative, which did not involve any expenditure, was to use the existing streaming rooms. These gave patients much greater privacy. We saw the private streaming room used effectively on our unannounced inspection.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated the trust leadership of its urgent care services as requiring improvement because:

- Changes in staffing had led to gaps in the management of the sub-contracted service at the UCC, although it was clear that the trust was addressing both during and after the inspection.
- Some clinical staff did not feel able to influence the way the service was run.
- Incident reporting in the UCC was low and did not feed directly into risk management.
- Although audits were undertaken at the UCC, there was less evidence to demonstrate the whether these had led to improvements in patient experience and patient care.

However

- There was a clear trust wide vision, strategy and mission statement. The trust had also developed core values with staff that we saw reflected in staff behaviour. There was a clear leadership structure and regular contact with the Clinical Commissioning Group and systems for monitoring and reporting on services. The trust oversight and management of the walk-in centre was effective, but the trust appeared to have less influence on systems at the UCC.
- Staff at all levels at both services worked well as a team to treat patients
- Notes of meetings were clear and actions for follow up were identified for the walk-in centre. Minutes were less clear for the UCC.
- Staff enjoyed working at the centres and considered they offered a good service. A higher proportion of responses from patients would help validate patient satisfaction.

Service vision and strategy

- Urgent care services were provided within the London-wide vision and strategy for these services.
- The trust had its own clear corporate vision, strategy and mission statement, and had developed core staff values that HRCH staff were aware of and demonstrated. Staff at the walk-in centre supported the mission of the trust to provide care that they and their families would want to use. They believed the well-established walk-in centre provided high quality, easy and convenient access to GPs and nurses when needed.
- The UCC staff worked at arm's length from the trust because the day-to-day running of the service was sub contracted. HRCH senior managers were involved in the oversight of the service through operational, contract and clinical governance meetings.The trust had identified some gaps in its management of the service due to changes in senior staff and this was being addressed at the time of our inspection.
- The flow of information from doctors and nurses to senior management in HRCH was through Greenbrook as specified in the sub-contract. However, locum and agency staff at the UCC did not seem aware of how the service fitted into the strategy of the community healthcare trust, or in some cases, even that the trust held the contract for the service.
- The UCC had a dual role in ensuring where possible that people who did not have serious conditions were referred back to their GP if their care needs were not urgent, while ensuring that other patients, many of whom required a small (although important) amount of clinical input were treated within a reasonable timescale.The trust were aware of the tensions resulting from public perceptions of the purpose of urgent care, to meet their convenience, and commissioners' objectives.

Governance, risk management and quality measurement

- The HRCH Associate Director of Adult Services oversaw the urgent care services. There was senior management involvement by different HRCH managers, for each service. We considered there was good oversight of safety and quality issues.
- HRCH had a contract with Hounslow CCG for providing the Hounslow Urgent Care Centre. The contract for the service clearly outlined the responsibilities of both parties and HRCH had made a conscious decision to sub-contract the day to day management of the service

to Greenbrook who had experience in managing a number of UCCs. However, a recent review of governance in HRCH had identified that they needed to strengthen their oversight of all sub-contracts and work on this was underway. There had been a pragmatic approach to changing operating practices, at the UCC in particular, to meet the challenges of increasing demand for the service, but there could have been more rigour in defining and recording service changes.

- Greenbrook and UCC both had medical leads. Greenbrook staff regarded their medical director as responsible for clinical safety, although the medical director of HRCH became involved in the event of a serious incident. We were aware that there had been some tension between the two organisations in the past, but we were assured that these were now being managed effectively. At operational level, the relationships appeared good.
- The CCG held bi-monthly review meetings attended by HRCH and Greenbrook, to review performance targets for the UCC and any issues about referrals to primary care. We saw minutes of these meetings. There was no data for some of the KPIs on the report we reviewed (January 2016), for example on information passed on to school nurses and health visitors by the second working day.
- HRCH led a quarterly management board meeting and a quarterly contract meeting with Greenbrook. We noted a number of discrepancies between the contract for the service and the service provided on the ground. We were subsequently given evidence that some agreements had been made with commissioners outside the contract, for example on blood tests and paediatric competences, that had not been reflected in contract amendments. Although contractual and management arrangements seemed complex, senior managers we spoke with were clear about the accountabilities. The distinctions between the roles of Greenbrook and HCRH were less clear to staff working in the UCC. However, this did not impact on the quality of care.
- HRCH chaired monthly clinical governance/ operational management meetings that a CCG representative attended. The meetings were in two parts: the first part of the meeting included designated representation from the emergency department at WMUH and discussed shared issues between the two collocated services; the second part of the meeting was between HRCH and Greenbrook. There was a standard agenda but the minutes were very brief, for example, there was no evidence of discussion on risk. Some of the minutes repeated identical wording from previous meetings in the same sections so it was not clear how accurately the minutes reflected discussions
- Risks identified at the UCC included safeguarding training, shortage of GPs, equipment problems and the absence of child friendly facilities. These were in line with the risks we identified, although we identified other risks such as the potential implications of very low incident reporting. The trust was aware of low incident reporting, and seeking to improve it, but we were surprised the trust had picked this up sooner. There was room to strengthen effective sharing of learning from incidents, complaints and audits to improve patient experience and embed improvements in practice. There could be a stronger link between reported incidents, particularly from serious incidents, and the risk register. Staff were not generally aware of what was on the risk register, and their role in reducing risk.
- HRCH had policies to support staff including induction, sickness, and whistleblowing that applied to both the walk-in centre and the UCC. Managers told us they were managing sickness absence more effectively than in the past and now held formal return to work interviews.
- An onsite HRCH manager was responsible for walk-in centre and other outpatient services at Teddington Memorial Hospital. There were regular meetings with the commissioning CCG (Richmond) to review performance.
- The local governance arrangements for the walk in centre were clear. HRCH had a service level agreement (SLA) with The Thames Health Collaborative Community Interest Company (THCIC) to provide GP cover in the evening and at weekends. Although HRCH had a medical lead, part of the agreement was that the GP service should also have a medical lead. There were quarterly meetings between THCIC and HRCH which reviewed incidents, complaints, compliment, any safety alerts, risks and estates issues
- Lead GPs attended monthly clinical governance meetings and reported outcomes to other GPs. They attended walk-in centre meetings when there was a relevant incident or complaint in line with the SLA. There was a monthly medication management meeting. A medicines report was submitted quarterly to the operational meeting.

Requires improvement

Are services well-led?

- Team meetings of nursing staff and the HRCH manager with oversight of the service were held every two months. These were minuted and included a review of incidents so all nursing staff were aware of these and could learn from them.
- The risk register was regularly reviewed. The risks were consistent with what we saw and what staff told us.
- Policies to support staff such as induction, sickness information governance and whistleblowing were available to staff. In 2015 the trust had re-launched a 'Speaking Up' (whistleblowing) policy. A 'Speak Up' guardian reported directly to the chief executive. The staff we spoke with told us they would have no problem in raising concerns.
- Walk-in centre staff had no contact with the urgent care centre that HRCH provided in Hounslow. This was because the HRCH provided the UCC in partnership with a different external partner, and the activities were commissioned by different CCGs with their own priorities. While recognising the contrasts, including patient demographics at the two services, we considered there was scope to share high level learning across services in two areas to the benefit of both.

Leadership of these services

- The UCC was led on a day-to-day basis by a Greenbrook-appointed on site manager with once a week visits from a head office manager. The on-site UCC manager was a recent appointment. It was too early to see the impact of this staff change, although we had some reservations about the depth of experience of the postholder. We have been told that an experienced clinician is now undertaking this role.
- Nurses and HCAs were aware that HRCH was their employer but identified more with the UCC than the trust. Staff said that most issues were sorted out at UCC level rather than being referred to HRCH. Agency nurses we spoke with were unaware that the HRCH held the contract for the UCC.
- Staff at the walk-in centre spoke positively about support from their immediate line managers. Some nurses said they were remote from the head office management although well informed about trust news in general through a newsletter and emails, as well as through information cascaded in meetings.
- The manager of the walk-in centre and other services at this site was visible and available to staff during our inspection.

Culture within this service

- Staff at both services stated there was good team working and colleagues were supportive.
- Nurses at the walk-in centre said they valued working with the small number of regular GPs who worked at the centre, and who helped them broaden their knowledge. The relationship between doctors and nurses at the UCC were less close because of the large number of different temporary doctors.
- Some staff we spoke with at the UCC did not feel suggestions they made were taken into account by management, for example the need for a second nurse at night to relieve pressure and to allow staff on duty to take a break, or the desirability of longer GP cover 'after school'. (Many GPs finished at 6pm when the UCC was still busy). There was some perception that targets and costs were a more important driver than prompt care.
- UCC staff we spoke with felt too much information was cascaded by email. They said there was little time for team discussions, aside from informal discussion in the nurses' station. Nurses at the walk-in centre felt there was a good balance of face-to-face discussion and written information. Although senior managers had told us there was a daily huddle to share operational information, this did not happen during our inspection because staff were too busy. Staff said it did not happen regularly, and there was no equivalent for evening staff.

Public engagement

- Both centres used the Friends and Family test to seek feedback from patients. Responses were reviewed at governance meetings, but the response rate was quite low.
- Service user involvement is recommended to influence and maintain optimum service delivery: College of Emergency Medicine's Minimum requirements for unscheduled care facilities (July 2009). We saw evidence of approaches to supplement the Friends and Family Test by collecting patients' views about the service. HRCH had commissioned a private company was carrying out a wider survey of experiences of urgent care patients. The results were not available at the time of our inspection.
- Although the theory behind unscheduled care was that patients were not regular attendees, a number of the patients we spoke to had attended the UCC several

Requires improvement

Are services well-led?

times. There was information on display at the centres to explain the role of different parts of the primary care service to help educate patients about the purpose of urgent care which was a missed opportunity.

Staff engagement

- The 2013/2014 NHS staff survey placed the trust in the top performing 20% of all trusts nationally for: staff motivation at work; staff receiving job-relevant training, learning or development; effective team working; staff agreeing that their role makes a difference to patients; staff having well-structured appraisals and other issues.
- The staff we spoke with felt supported by their immediate managers and told us the trust was a good place to work. This was supported by the results from the most recent staff survey and the staff friends and family test.
- There was no breakdown of the Staff Friends and Family test for urgent care, but trust wide results showed a high level of staff would recommend treatment at the trust (85%), and 65% of staff would recommend it as a place to work. Staff we spoke to enjoyed working at the centre although some would like to be more involved in developing the service.
- Staff working at the UCC did not really feel part of the trust and identified more with the sub-contractor, Greenbrook.

Innovation, improvement and sustainability

- The patient champion role is an innovation, not used to this extent elsewhere. The patient champion actively helps patients not registered with a GP to register with a GP near their home and also helps patients who should more appropriately be treated by a GP to make an appointment. This has been well received by the public.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided because; 1. Reporting and analyses of incidents were not done effectively, so that lessons can be learned and shared with relevant staff to ensure improvements in the service to patients. Regulation 17 (2)(b)