Urgent Care Centre Queen Mary Hospital

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Urgent Care Centre Queen Mary Hospital on 3 November 2016. The overall rating for the practice was good. However, a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified, and we rated the practice as requires improvement for providing safe services. The full comprehensive report on the November 2016 inspection can be found by selecting the 'all reports' link for Urgent Care Centre Queen Mary Hospital on our website at www.cqc.org.uk.

This inspection was a desk-based follow up inspection carried out on 7 September 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 3 November 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

The practice is still rated as requires improvement for providing safe services, but remains rated as good overall.

Our key findings were as follows:

- The provider had updated their policies and documents in relation to dealing with significant events and ensuring business continuity to reflect the arrangements at the service
- The service had improved its performance against National Quality Requirements, butwas not yet meeting set targets
- The provider had a centralised system for risk reporting and management
- The service has a translation service for patients who need it

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

The provider must:

- Continue to improve its performance against National Quality Requirements

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was an effective system for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the service.
- The service had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.
- The provider had updated their policies and documents in relation to dealing with significant events and ensuring business continuity to reflect the arrangements at the service
- However, although the service had made improvements, they were still not meeting targets for the time in which patients should be triaged at both the urgent care and out of hours services.

Urgent Care Centre Queen Mary Hospital

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Urgent Care Centre Queen Mary Hospital on 3 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Overall, the practice was rated as good, but was rated requires improvement for providing safe services.

We set the provider a requirement notice as follows:

Regulation 12 HSCA (Regulated Activities) Regulations 2014 (Safe care and treatment) because the practice did not have an effective system for ensuring that patients were triaged in a timely manner.

We undertook this follow up desk-based focused inspection of Urgent Care Centre Queen Mary Hospital on 7 September 2017. This inspection was carried out to check that the provider had taken action to comply with legal requirements.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 3 November 2016, we rated the practice as requires improvement for providing safe services as the service did not ensure that definitive clinical assessments were started within the timeframes set by National Quality Requirements (NQRs) for patients attending out of hours for urgent needs, or routine needs. This related to both the urgent care and out of hours services. In addition, targets for streaming patients on arrival were not being met. The service had not ensured their business continuity plan and serious untoward incidents policy accurately referenced and reflected the records system in use in the service. The service should consider bringing all identified risks into registers managed by the service, rather than rely on those used by the owner of the building.

These arrangements had improved when we undertook this desk based follow up inspection on 7 September 2017. However further improvements are still needed, so the practice remains rated as requires improvement for providing safe services.

Safe track record and learning

At our last inspection, we found that the policy for serious events, taken from a pro-forma used by Hurley Group, was not fully adapted to meet the needs of the service. For example, the reporting form in the policy was not the same as the one used by the service. At this inspection, we found that the policy had been updated and reflected the site arrangements for reporting significant events.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety.
- From 1 January 2005, all providers of out of hours services have been required to comply with the National Quality Requirements (NQR) for out of hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group on their performance against standards which includes audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.
- At our last inspection we found that the service was not always meeting targets set out in the NQRs. At this inspection, the provider sent us evidence of the actions they had taken and performance figures in support of improvements they had made in meeting target times for streaming patients. Particularly, the provider had employed an operations manager in the OOH period to focus on implementing a continuous training plan for the staff team, which included clinical and non-clinical, permanent and locum staff. The training focussed on practical changes the staff could make to help them improve their performance against the National Quality Requirements. These included familiarisation with the definitions of the targets, use of the integrated health record to support clinicians in completing assessments, and sharing information about breaches as learning opportunities
- All patients attending the urgent care centre were triaged by a clinician who determined the care pathway for each patient. Targets for this were set as being within 15 minutes of arrival for children and within 20 minutes for adults, and for them to meet these targets at least 95% of the time. At our last inspection we found that the targets were met in the preceding three months between 55% and 73% of the time. The service had identified this as a risk, and reported that they had commenced a review of this with a view to improving. At this follow up inspection, we found that the service's monthly performance in meeting the target for children between January and August was as follows: 72%, 69%, 65%, 70%, 73%, 80%, 73% and 85%. Their monthly performance for meeting the target for adults in the same period was as follows: 82%, 80%, 79%, 82%, 81%, 80% and 90%.
- The NQRs require that the service start definitive clinical assessment for out of hours patients with urgent needs within 20 minutes of the patient arriving at the out of hours centre in at least 95% of cases. In the three months prior to our previous inspection, the service began clinical assessment of these patients between 71% and 80% of the time. At this inspection, we found

Requires improvement

Are services safe?

that the service had improved its performance in meeting NQRs in this area. During January to August 2017, their monthly performance was as follows: 77%, 72%, 77%, 87%, 85%, 89%, 80% and 82%.

- NQRs require that the service start definitive clinical assessment for all other out of hours patients within 60 minutes of the patient arriving at the out of hours centre in at least 95% of cases. At our last inspection, we found that in the three months prior to the inspection, the service began clinical assessment of these patients between 73% and 78% of the time. At this inspection, we found that the service had improved its performance in meeting NQRs in this area. During January to August 2017, their monthly performance was as follows: 52%, 69%, 66%, 87%, 82%, 88%, 89% and 91%.
- The above figures show the service's performance had improved, but they were still not meeting the 95% of instances targets for the time in which patients should be triaged at both the urgent care and out of hours services.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to respond to emergencies and major incidents.

At our last inspection, we found that the service's business continuity plan did not include CCG or NHS England contacts, and referred to EMIS (a clinical records system used in GP surgeries) and paper records which were not in place on the premises. At this inspection, we found that the service's major incident and business continuity plan had been updated to reflect current working practices and included the previously omitted information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The practice did not have an effective system for ensuring that patients were triaged in a timely manner. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.