LCW UCC (St Charles Centre for Health and Wellbeing)

Inspection 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 location	Good
Are services safe?	Requires Improvement

Overall summary

The service had previously been inspected on 25 and 26 August 2022. In this inspection the service was rated as good overall, but requires improvement in the safe key question, and found to be in breach of regulation 12 of the Health and Social Care Act 2008.

The full reports for previous inspections can be found by selecting the 'all reports' link for LCW UCC (St Charles Centre for Health and Wellbeing) on our website at www.cqc.org.uk

We carried out this announced focused inspection of LCW UCC (St Charles Centre for Health and Wellbeing) on 26 July and 1 August 2023. We found that some of the breaches of regulation from the previous inspection had been fully addressed, but in one area there was more to do. Following this inspection, the key questions are rated as:

Are services safe? – Requires improvement.

The registered manager is the Chief Executive Officer. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- The service had developed systems such that learning from incidents and safeguarding processes were shared with all staff at the service.
- The service was not meeting targets for ensuring that calls were answered in a timely manner, and abandoned calls avoided. These targets are measured to ensure that safe care is provided.

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

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

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

Our inspection team consisted of a CQC lead inspector only.

Background to LCW UCC (St Charles Centre for Health and Wellbeing)

London UCC (St Charles Centre for Health and Wellbeing) is a registered location provides the 111 service to the North Centre region of London. The service also provides 20% of health advisor time and 50% of the Clinical Assessment Service (CAS) support to the North West London region, although another provider is lead contract holder in this area.

All of the services are provided from a single core location, St Charles Centre for Health and Wellbeing, London, W10 6DZ. However, most of the clinical staff that support the 111 service work remotely.

In both the North Central (the Boroughs of Barnet, Camden, Enfield, Haringey and Islington) and North West London (the Boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster) areas, the service provides a Pathways-led triage system with input from a clinical assessment service (CAS) as required. The service refers to patients to a variety of services in the local area, including Urgent Treatment Centres (UTCs), out of hours services, and referral back to a patient's own GP service.

The service is delivered by London Central and West Unscheduled Care Collaborative Limited (LCW). LCW currently manages the 111 service, plus CAS and out of hours services in the local area.

The service is a 24/7, 365 days per year service for patients to call so they may be redirected to the most appropriate service. Calls are taken by Health and Service Advisors who are employed by LCW, with management and governance structures in place at the service.

CQC registered the provider to carry out the following regulated services at the service:

- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely

The service's website address is www.lcwucc.com

Requires Improvement

Are services safe?

We rated the service as requires improvement for providing safe services.

We previously carried out an announced comprehensive inspection on 25 and 26 August 2022. At the time of the last inspection the service was not providing safe services, and we found the following:

- The service was not meeting targets for ensuring that calls were answered in a timely manner, and abandoned calls avoided. These targets are measured to ensure that safe care is provided.
- Not all staff at the service were aware of incident reporting or safeguarding processes, and learning from incidents and complaints was not routinely shared.
- Staff we spoke with told us that there were insufficient health advisors and clinical staff at the service. We noted that there were gaps in rotas that were not filled.

At the time of this inspection visit between 26 July and 1 August 2023, we found some of the issues had been addressed However, some breaches in regulation remained. Specifically:

- The service was not meeting targets for ensuring that calls were answered in a timely manner, and abandoned calls avoided. These targets are measured to ensure that safe care is provided.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had safety policies which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Systems were in place to ensure that clinical staff and team leaders took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. Staff were aware of safeguarding processes, which were signposted throughout the call centre, including details of the safeguarding lead.
- The premises at the site were fit for purpose. Facilities and equipment were safe, and equipment was maintained according to manufacturers' instructions.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety.

- The service regularly monitored the number of calls abandoned and time to answer calls, which are safety requirements required to be monitored and figures submitted to the commissioners.
- Call abandonment rates were generally between 8% and 30% for the last twelve months, although in one month this was 46%. The organisation had been given a 5% target, which had not been met at any point during the last year. The service had delivered similar performance results to a number of providers in England in the last year, but rates were still below national targets.

Requires Improvement

Are services safe?

- The number of calls answered within 60 seconds in the last 12 months was between 19% and 63%, lower than the 95% target. Average waiting time was over a minute in each of the last 12 months, and in three months was over ten minutes. Again, the service had delivered similar results against these targets compared to other providers in England in the last year, but targets were still below national targets.
- There were arrangements for planning and monitoring the number and mix of staff needed, although the service stated that recruitment to all posts was difficult given a shortage of appropriately trained staff. Staff at the service told us that senior managers had been proactive in addressing staffing shortages and that they were confident that this would be addressed.
- There was an effective induction system for both permanent and temporary staff tailored to their role including mandatory training in Pathways where required.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and escalate those patients with most urgent needs. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits or who had been inappropriately streamed into the service.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff, the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including Urgent Treatment Centres (UTCs), out of hours providers and local ambulance providers.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Requires Improvement

Are services safe?

- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. This included reviews with local out of hours providers.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The service was not meeting targets for ensuring that calls were answered in a timely manner, and abandoned calls avoided. These targets are measured to ensure that safe care is provided. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.