Medway Community Healthcare C.I.C

Community urgent care service

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Community urgent care service

Requires Improvement

Medway on Call Care (MedOCC) provides urgent care services in three sites across Medway and Swale. Staff at urgent treatment centres see and treat people who require medical attention, where their condition is not life threatening.

We rated the service overall as requires improvement and safe as inadequate because:

- The service did not ensure patients were clinically assessed within the required timeframes in line with NHS England's standards. Staff were not continually monitoring patients to mitigate against the risk of their condition deteriorating while they waited. Patients who were too unwell to be seen at the urgent treatment centre (UTC) were kept waiting for long periods before they were sent to the A&E department.
- The environment was not cleaned to a high standard and toilets were dirty. This could expose staff and patients to risks of infection.
- The security arrangement in terms of who could enter the department were insufficiently robust to keep staff and patients safe. Staff were not always aware of who came into the department. The CCTVs monitoring people in the department were not in operation at the time of our inspection.
- Managers did not ensure all staff had regular clinical supervision and appraisal.
- Staff were not completing face to face mandatory training in line with the providers' target. Managers did not always ensure that staff accessed specialist training where appropriate.
- Staff did not always record consent to treatment for patients.
- The service leaders did not ensure that the safeguarding alert system worked effectively and that all staff were aware of how the system worked.
- Staff did not always ensure medicines were stored correctly. Injectable medicines were not in their original container and different strengths were mixed.
- The service did not ensure that records were completed thoroughly and kept up to date.
- The service did not ensure that there was enough information including self-help and health promotion materials readily available to patients and families.
- The service did not ensure all aspect of its governance processes were robust and effective. For example, although service level risk was being monitored, there were no clear actions to address any improvements that were needed. In addition, managers did not ensure employee records were up to date.

However:

- Staff were kind and caring. Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service had enough staff to care for patients and keep them safe.

Our findings

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Staff worked across health care disciplines and with other agencies when required to care for patients.
- Leaders had the skills and experience to lead the service. Staff spoke highly of their leaders. There was an open culture and staff felt managers listened to them.

A summary of CQC findings on urgent and emergency care services in Kent and Medway.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Kent and Medway below:

Kent and Medway

The health and care system in this area is made up of many health and social care providers and is supported by stakeholders, commissioners and the local authority. We found front line staff working across all services were doing their best in very challenging circumstances and had continued to do so throughout the COVID-19 pandemic.

Increased system wide collaboration, particularly between health and social care was needed to alleviate the pressure and risks to patient safety identified in some services we inspected. However, we did find some good collaborative working; for example, staff in acute and ambulance services had been working together to reduce handover delays, and primary and community services worked together to reduce attendances in Emergency Departments.

We found some access issues in primary care and some GP practices were not allowing patients to enter the building without staff permission; since our inspections, action has been taken to ensure patients can access their GP Practice freely. We did find examples of innovative practice including employing a variety of different healthcare professionals in GP Practices and across Primary Care Networks to better meet the needs of their patients ensuring people receive the right care at the right time. There was also funding available to provide interpreting and translation services to support people from diverse communities and to support people arriving in the UK from Ukraine.

Primary Care Networks were working well with community services to alleviate the pressure on ambulance and acute services where possible, particularly in out of hours services. In addition, technology was being utilised to improve services and provide timely access to patient information, especially for staff providing out of hours care.

Staffing issues and high levels of absence due to COVID-19 had impacted on services across Kent and Medway. GP Practices in this area had a larger number of patients per GP and demand had increased; however, in many cases this was well managed. The NHS111 service had experienced staffing issues as well as increased demand; this had resulted in significant delays in call answering times for people trying to seek advice.

Ambulance response times had also been poor across Kent and Medway. Whilst operational staff had done all they could to maintain response times to serious and life-threatening calls, response times to less serious calls were unacceptable, and performance had continued to be poor for a long time. This had widespread impact on people in Kent and Medway, and particularly on people living in care homes. Social care staff had to provide long periods of enhanced care to people waiting for an ambulance response whilst also caring for other residents.

Our findings

There continued to be long ambulance handover delays at hospitals in Kent and Medway; however acute and ambulance services had worked well together to reduce these delays and improve handover processes.

Emergency departments inspected in Kent and Medway continued to be under significant pressure. However, we found some improvements since previous inspections, including improvements in leadership and the culture within the departments. Staff worked hard to meet current demands and felt positive about the improvements they had seen. Some social care services had raised concerns in relation to the care provided to people with dementia and autism in emergency departments. Where specific concerns were raised, these were being investigated.

There were delays in patients receiving care and treatment caused by poor patient flow across urgent and emergency care pathways. There were many urgent and emergency care pathways available within hospitals in Kent and Medway, however staff acknowledged these were not all working well or being fully utilised. Referral pathways between emergency department and urgent treatment centres aimed to meet people's needs and reduce pressure on acute services. However, we identified issues with inappropriate referrals, long waiting times and inconsistent risk assessments putting people at risk of harm. Patients also reported delays in their treatment due to inappropriate referrals. System partners were aware of issues with UEC pathways and had an action plan in place to address them.

We also found delays in patient discharge from hospitals and a shortage of social care capacity to enable people to leave hospital in a safe and timely way. In addition, social care services reported concerns about poor discharge processes. Examples included insufficient information about changes to medicines or people discharged into care homes who required a level of care for which staff were not trained to provide.

Staff working across Kent and Medway require additional support to manage the continued pressure on services. We also identified opportunities to upskill staff, for example, training additional social care staff in areas such as detecting early signs of deterioration in health. Increased collaboration between health and social care services and stakeholders is needed to address issues with patient flow across urgent and emergency care pathways. These pathways also require evaluation to ensure they are as efficient and effective as possible to meet the needs of people in Kent and Medway.

Background to inspection

Medway On Call Care (MedOCC) is run by Medway Community Healthcare CIC, which is an independent Community Interest Company, co-owned and has 1,359 staff. As a social enterprise they are not for profit organisation and reinvest any surplus back into health and care services and the local community.

MedOCC provides urgent care services in three sites across Medway and Swale.

The urgent treatment centre (UTC) at Medway Maritime Hospital operates a 24 hour service where the teams see patients who were referred via the NHS111 service or streamed from the acute trust. The UTC front door is operated by staff from the acute trust who are responsible for the initial clinical contact of patients presenting to the department. The streaming to MedOCC takes place at the UTC front door by the acute trust clinical staff."

The urgent treatment centre (UTC) at Medway Maritime Hospital operates a 24 hour service where the teams see patients who were referred via the NHS111 service or the accident and emergency department. The service does not accept walk-in patients.

Our findings

The urgent treatment centre at Sheppey Community Hospital is shared with Kent Community Health NHS Foundation trust who provides urgent treatment in hours, while the MedOCC provides urgent care service on weekends and out of hours on Mondays.

The UTC at Sittingbourne Hospital is currently closed.

MedOCC UTC is also commissioned to assess and manage patients with symptoms of cellulitis or deep vein thrombosis. The service acts as a communication hub for messages to district nurses, rapid response teams and other community and specialist teams.

The service is registered to provide the following regulated activities: Treatment of diseases, disorder or injury and Transport services, triage and medical advice provided remotely.

There are two registered managers.

MedOCC has previously been inspected as an out of hours service under the name MedOCC -Quayside in November 2014.

What people who use the service say

Feedback from patients was generally positive. The service had received a lot of compliments from people who used the service. Patients, families and carers felt that staff were generally kind and caring.

People who used the service felt it was accessible for them especially as there were not enough GPs in the area, and it was often very difficult for them to get an appointment with their GPs.

Patients felt they always had a good outcome following their visit. However, they felt service could improve on the very long waiting time, triaging process, and communication could be better.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

• are services safe?

• are services effective?

• are services caring?

• are services responsive?

• are services well-led?

Before the inspection visit, we reviewed information that we held about the location.

Our findings

During the inspection visit, the inspection team:

• looked at the quality of the environment and observed how staff were caring for clients

• spoke with nine patients and carers

• spoke with the head of service

• spoke with the medical director

• spoke with 15 other staff members: including managers, doctors, pharmacists, nurses, clinicians, reception, and admin staff

• observed patient consultation with clinicians

• looked at 14 care and treatment records

• looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is the service safe?

Inadequate

Mandatory training

Staff did not keep up to date with their mandatory training.

Staff were not completing their mandatory training in line with provider's target. For example, the training rates for moving and handling practical, basic life support (BLS) practical and intermediate life support (ILS) were 33%, 55% and 18% respectively with a target of 85%.

Managers informed us that the reason why the face to face training was low was because most of the trainings were cancelled due to COVID-19.

Managers told us they reminded staff who had not completed their mandatory and statutory training to do so. Managers told us that the face to face trainings were also being rescheduled.

Safeguarding

Our findings

Although staff understood how to protect people from harm and abuse, we were not assured the safeguarding process was robust enough to protect people from abuse. The safeguarding alert system to inform staff when a child was a safeguarding concern was not working effectively. The completion levels of safeguarding training were below the provider's target.

The service had a comprehensive safeguarding training which all staff were required to complete. Although staff were completing their safeguarding level one training for adults and children, the training rates for safeguarding level two for adults and children were below the providers target of 85% at 78% and 72% respectively.

Managers and clinicians knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. However, during the inspection, we saw that the system did not always alert all staff when a child who was on the child protection register or those with safeguarding concerns were in contact with the service. We raised this with the provider following the inspection and the provider explained that there was an alert system within the patient record system to inform staff when there was a safeguarding concern including cases where external agencies such as social services were involved.

The safeguarding lead informed us that the service in the last six months had signed up to the Child Protection Information Service (CPIS) where the teams could share information about any child on the child protection register. When a child on the register was being seen by MedOCC an automatic alert system is sent to the home agency including their GP and social worker. Additionally, in cases where a patient leaves before being seen, clinicians reviewed their medical records to determine if there was a safeguarding action to be taken before the case was closed.

The service now had access to a shared clinical record system with local trusts and were able to see palliative patients and patients on 'Do Not Attempt Resuscitation' (DNARS). Any patient with a safeguarding flag had a special note linking all information and given a bypass line, so they do not need to call NHS 111. Managers told us they would normally call back people in the vulnerable group within 20 minutes of contacting the service.

Staff knew how to make a safeguarding referral and who to inform if they had concern, and the teams knew who the safeguarding lead was. The safeguarding process was clearly displayed in the consultation rooms, and staff informed us they always asked the parent or carer if there were any safeguarding concerns or whether social services were involved.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

The premises were not cleaned to a high standard and non-clinical waste was not disposed of on time. However, staff managed clinical waste well.

Staff did not ensure that the environment was clean. All three toilets we saw were dirty and poorly maintained. The patient toilet was very dirty and the cabinet in the toilet was taped shut with a masking tape. The female toilet was dirty, and the male toilet floor was discoloured around the urinal.

Staff told us the housekeeping team from the acute trust were responsible for carrying out the cleaning. The house keeping visited once a day. The service operated 24 hours, seven days a week, and there was no cleaning schedule for the service. Reception and clinical staff often did the cleaning which increased their workload.

Our findings

Staff told us that the bins were often overfull, and they needed to remind housekeeping staff to empty them.

Managers informed us that infection prevention and control was one of their top risks and there were ongoing conversations with the acute trust to address this.

There was a COVID-19 policy in place and staff were required to read and understand it. The service practised safe distancing measures and staff and patients were to wear a mask when in the service and when they are able to. Managers regularly updated staff when there was a change in COVID-19 guidance.

The service carried out a monthly hand hygiene audit and results showed 100%. Staff told us if the scores were below 95% the service would be reaudited.

The service had an IPC link nurse who was responsible for carrying out environmental and infection prevention and control audits. The service had a decontamination process in place. Sharps and decontamination audit were completed quarterly, and results were 92% and 100% for the last quarter.

All staff were bare below the elbow, and they practised good donning and doffing techniques. The service had enough personal protective equipment (PPE).

Clinicians ensured that the consultation rooms were clean, and equipment in constant use such as stethoscope and sphygmomanometer were cleaned thoroughly between patients.

Staff disposed of clinical waste safely.

Environment and equipment

The layout, design of the environment, and use of the premises did not sufficiently mitigate patients' risk. However, staff managed clinical waste well.

The facilities and premises at MedOCC urgent treatment centre at Medway Maritime hospital did not sufficiently meet the needs of patients and families. The service was extremely busy and reception staff were required to monitor people in the waiting rooms including people in the separate paediatric waiting area.

During our inspection we saw that there were no CCTV in operation to monitor people in the waiting area which meant reception staff were not always aware of who was in the department. Staff could not always monitor patients who were at risk of deterioration. For example, one adult patient who was very unwell was sitting in the children's waiting room and staff were unaware of this. A parent had to alert staff who then took the patient to an assessment room.

We raised this with the provider, who informed us there were CCTV in place that covered the whole of the department. However, due to the ongoing building works, some cameras worked intermittently. The provider also informed us that all CCTV cameras will be fully operational by the end of May 2022.

The paediatric waiting room did not have any decorations or murals and was not child friendly. There were no recreational activities appropriate for children while they waited in line with the Royal College of Paediatrics and Child Health (RCPCH) guidelines. Staff told us they had to remove certain items to reduce risk of COVID-19 infection. Managers informed us that there was a business case to get art students from one of the local colleges to paint and redecorate the children waiting area as part of working with the local community.

Our findings

There were insufficient security arrangement in place to protect staff and patients. There were two entrances for people visiting the service. However, staff were not always aware of the people coming through the unit. People were using the unit as a thoroughfare to get to other parts of the hospital. People who did not have an appointment could easily walk through or sit in the reception area as there was no security to check who was in or came through the department.

There were a row of heavy chairs between the reception staff desk and patients. Staff told us this was to stop people getting too close to the glass window while they clerked them in, to prevent COVID-19 spread. This was inconvenient to patients using the reception desk and we saw a patient bump into the chair whilst trying to speak to reception staff.

The site was adjacent the acute trust's main entrance. There was a stock room on entering the unit which was used previously as the reception room. We saw there were gaps in the window, and anyone walking past could see dressings and medical stock which was partially boarded. It was relatively easy for anyone to take stock through the gap in the window. The provider informed us following the inspection that the stock room was being used temporarily and the area was covered by CCTV.

Managers told us the unit was undergoing some refurbishment work and there were plans for a CCTV to be installed in the paediatric waiting room.

The service had ample number of rooms for clinical assessment and were close to the main wating area. There were 10 consultation and assessment rooms presently and managers informed us they were increasing the number of rooms to 12 in the new build in order to meet the needs of more patients.

Staff told us due to the ongoing refurbishment work, the potential disruption that estates work could cause was on the risk register.

Staff carried out daily safety checks of specialist equipment. The nursing team checked the emergency trolley at least once daily, and twice after use. The emergency trolley was in use at the time of our inspection to attend to a medical emergency.

Staff could access support from the acute trust or ambulance when they needed to move patients whose condition had deteriorated. However, the service did not have a dedicated patient trolley.

Assessing and responding to patient risk

Staff did not consistently complete a thorough risk assessment for patients on arrival. Staff did not ensure that patients at risk of deterioration always received timely intervention. However, staff responded well to people with mental health concerns.

Staff did not always ensure that patients attending the urgent treatment centre (UTC) had a timely clinical assessment and that appropriate actions were taken to mitigate risk of people's health deteriorating. The NHS England Urgent Treatment Centres – Principles and Standards July 2017 requires that patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time. However, patients were waiting over two hours before they were seen.

Our findings

MedOCC UTC did not take “walk-in” patients. The majority of patients who attended the service came via the accident and emergency unit (A&E) where they were clinically streamed by a senior practitioner. Streaming is a rapid assessment process which involves taking a brief history and performing basic observations if appropriate which informed triage prioritisation. Streaming usually involves calculating of an early warning score for example the national early warning score (NEWS) for adults or paediatric equivalent for appropriate patients.

Although staff told us that the A&E staff would normally stream patients within 20 minutes of arrival, staff did not ensure that patients who were very unwell were seen quickly to reduce the risk of deterioration. A&E staff did not always carry out triage or early warning assessments before sending patients to the UTC and the UTC staff did not carry out initial triaging.

Patients were consistently being sent to MedOCC UTC who were too unwell to be seen at the service. For example, we spoke with two patients who had chronic chest pains and one patient had to return to A&E due to incomplete echocardiogram (ECG). We reviewed three complaints of patients who had miscarriages who had been sent to the urgent treatment centres where their physical health needs were not met in a dignified way. One patient complained they were waiting at the UTC for over an hour before they were asked to return to A&E. Between August 2021 to February 2022, there were 284 inappropriate patient referrals that were taken back to A&E.

Staff informed us that due to patients being wrongly streamed, there had been increased verbal aggression from patients when staff informed them to return to A&E, as they could not be seen in the UTC. Some of these patients had waited a number of hours.

Staff told us there was a rapid review process where patients at risk of deterioration were seen quickly. However, staff were unsure of how the rapid review process worked and what the timeframes were. Some staff told us the rapid review process commenced after three hours of waiting, while others thought it was two hours. We spoke to one patient who could not sit down because of pains around their back and chest and had been standing for over two hours. The patient had not been assessed by staff. Another patient was in obvious physical pain and was unable to speak. Staff did not ensure they were comfortable, and the patient was not seen immediately.

Managers told us that patients in the waiting room were visible to reception staff who could alert clinicians when a patient’s condition was deteriorating using an emergency “green button”. However, there were usually a lot of patients in the waiting area and reception staff had not received any specific training on how to recognise patients who were at risk of deterioration known as “red flags”. Managers told us that reception staff were very experienced and were able to recognise when a patient’s condition was at risk of deteriorating and they would normally escalate this to clinicians.

The service did not utilise the NHS Safety Thermometer tool which checks for patients at risk of falls, venous thromboembolism (VTE), pressure ulcers and infections. One patient who was diagnosed with sepsis was sent to A&E to commence Sepsis Six. The components of the Sepsis six include blood cultures, checking full blood count and lactate, IV fluid challenge, giving IV antibiotics, monitoring urine output and administering oxygen: all to be delivered within one hour of the initial diagnosis of sepsis. Although we saw that the consultation rooms had a sepsis protocol posted on the wall to guide clinical decisions. The provider reported that infection and risk of VTE was always considered during clinical consultation, and that as a non-NHS organisation, they have decided not to fully utilise the NHS Safety thermometer.

There was a separate waiting area for patients who could not wear a face mask due to their condition. Doctors and clinicians often walked around the unit to call out patients’ names for their appointments.

Our findings

The service had 24-hour access to mental health liaison and specialist mental health support, if staff were concerned about a patient's mental health. The provider led an integrated locality review programme which involved teams from the mental health trust that met weekly to discuss patient care.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Staffing

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, and experience to deliver safe care treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service operated a four weekly rolling rota and managers adjusted staffing numbers and skill mix according to patients' needs and acuity levels. The number of nurses and healthcare assistants matched the planned numbers. About half of the shifts were covered by full time staff while the other half were covered by either bank, locum or agency staff. Staff told us there were huge pressures on staffing and workload had increased. The number and acuity of patients they saw daily had increased.

The service had successfully recruited for nursing and administrative staff, and the vacancy rates for these staff groups was reducing.

The service's turnover and sickness absence rate had been stable in the last 12 months. The service was managing absence through adding extra shifts. There was a staff WhatsApp group which managers used to inform staff where there were gaps in the rota and whether people would like to do extra bank shifts.

Managers requested agency staff familiar with the service, to ensure there was consistency.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Managers calculated staffing requirements using a staffing matrix. The service had four medical doctors on full time employment and 15 locum doctors who worked regularly for the service. The planned staffing rota was 10 clinical staff during the hours of 8am to 10pm. There were three doctors out of hours that worked across Medway Maritime Hospital and Sheppey Community Hospital sites.

There was always a GP on every shift, although sometimes the service operated with less than the planned staffing numbers. For example, we saw on two occasions in January 2022 where there was only one GP out of hours when they planned to have three on shift.

Our findings

The service had delegated managers who completed, reviewed and managed the staffing rotas which were planned two months in advance. Managers told us when there were gaps in the medical doctor's rota, they would usually send emails to their own GPs to request for cover in the first instance. Managers could also send GPs short notice request directly when they were short of medical cover, and they also used WhatsApp group to inform salaried GPs when there were extra shifts.

Managers informed us that the introduction of IR35 HMRC tax avoidance scheme has had an impact on recruitment and retention of locum staff. However, managers could go to higher rates for locum and agency staff when required.

Managers made sure locums had a full induction to the service before they started work.

The sickness and absence rates for medical staff had been relatively stable in the last 12 months.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, staff did not always ensure records were consistently updated.

Patient notes were comprehensive, and clinical staff could access them easily.

Staff told us when patients transferred to the service, there were usually no delays in staff accessing their records which was usually within 20 minutes.

Records were stored securely. Staff could only access patients' records if they had the necessary privileges and credentials.

Although we saw on inspection that most patient records were kept up-to-date, some of them had key information missing. For example, out of the 14 care records we reviewed, four of them did not have consent to treatment clearly documented, three of them did not have allergies recorded and three of them did not have records of observation.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines.

The provider employed a lead pharmacist who advised the service on the safe and effective use of medicines. A second pharmacist practitioner who worked one shift a week also advised the service.

The service had policies for the safe management of medicines and for prescribing.

Medicines were stored securely in clinical areas. However, some injectable medicines were not in their original containers and different strengths were mixed. This could increase the likelihood of the wrong strength medicine being selected.

Clinic rooms were clean and tidy. Staff monitored ambient and fridge temperatures and they were within the recommended range.

Our findings

Staff checked medicine stock levels and expiry dates regular, including emergency medicines and oxygen. There was a process for ordering replacement stocks.

Unwanted and expired medicines were disposed of safely.

Prescription stationery was stored securely, and there was an effective process to track prescriptions issued.

Staff conducted medicines audits. We saw that actions to improve issues identified were mostly completed.

The service had a system for reporting medicines related incidents. The service had reported four medicine related incidents since October 2021.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had a system in place for managing incidents. There were designated leads who reviewed incidents. The clinical lead was responsible for reviewing all clinically related incidents, and the team leaders were responsible for reviewing all administrative incidents while the quality and assurance manager was responsible for reviewing all medication related incidents. Incidents management was overseen by the head of patient safety.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy, and managers encouraged them to do so. Staff told us all incidents were reported via the provider's incident reporting system.

Managers investigated incidents and shared learning with the teams. Learning from incidents were discussed at senior leadership meetings and cascaded down via the team meetings. Staff were also made aware of learning from incidents which may have occurred in other teams via the two monthly clinical bulletins.

Managers ensured that patients and their families were kept up to date with incident investigations.

Staff understood the duty of candour. They told us it is about being open and transparent when things when wrong and offering an apology.

The provider had in place a formalised debriefing process to support staff after serious incidents. Staff told us managers were supportive, and that they could speak to them following any serious incident. However, some staff felt debriefing sessions following a serious incident could be more frequently offered.

Managers shared learning with their staff about never events that happened elsewhere. The service had not reported any never events in the last 12 months. *Never events* are when accidents occur due to errors, which could have been prevented.

Staff learned from safety alerts and incidents to improve practice.

Our findings

Is the service effective?

Requires Improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff delivered evidence-based care and treatment to patients. The provider had a group of clinicians who reviewed and updated any new and relevant guidance, including the National Institute for Health and Care Excellence (NICE) guidance every month. The team ensured staff were promptly aware of any urgent guidelines, for example, new protocols for COVID-19 or changes in the British National Formulary (BNF).

Staff handed over patients to other clinicians or services via the information sharing system, including any psychological or emotional needs of the patient. Staff told us due to the nature of the service, there were no structured face-to-face handovers or safety huddles.

Clinicians ensured all cases were dealt with and closed by the end of their shift. In the event a patient needed follow up, staff ensured they were handed over to their GPs or other specialities.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. For example, reception staff normally alerted clinicians to patients who appeared distressed. Managers informed us that they would normally move patients with mental health problems up the queue to be seen quicker. Staff ensured patients had access to advocacy when required.

Nutrition and hydration

Staff ensured patients had access to food and drinks to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

The service had a cold water dispenser for patients who needed a drink. Staff were also able to make hot drinks for patients who requested it.

Hot and cold food and drinks, as well as light refreshments were readily available from the acute trust's café which was very close to the UTC.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff referred patients to specialist support such as dieticians and speech and language therapists for patients who needed it.

Pain relief

Our findings

Staff assessed patients to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. However, staff did not consistently respond to patients who were in obvious pain in a timely way.

Staff prescribed, administered, and recorded pain relief accurately. Patients told us when the initial pain medication they were prescribed did not ease their pain, staff investigated this, and prescribed alternative pain medication.

Staff on most occasions, assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. For example, staff used a numerical rating scale to assess the severity and intensity of pain and how the patients were responding to it. Although, we saw a patient in obvious pain was waiting for over an hour before they were assessed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, the data did not always reflect better outcomes for patients.

The service monitored patient outcomes on timeliness, readmission to the service, waiting times and performance. The service also measured outcome on the number and types of complaints and compliments received.

The service was not meeting its waiting times targets which meant that some patients were not receiving the service they needed in a timely way.

Patient feedback was generally positive, and the service had received a huge number of compliments in the last 12 months.

The service had a flagging system in place for patients who had been in contact three times within the last seven days. There was also a flag for people who reattended within the month and last 12 months. Staff told us if there were any concerns with patients frequently presenting to the UTC, they would escalate this to their GPs. Patients who attended frequently were discussed in the primary care network multidisciplinary team meetings, and then followed up where appropriate.

The GPs attended home visits for patients who are too unwell to attend the service in person. They could also prescribe remotely preventing people attending the A&E unit.

Managers told us they always followed up patients who did not attend their appointment or did not wait to be seen to ensure they were okay before they closed the case.

Competent staff

Managers did not ensure all staff had received an appraisal. Staff reported that managers were generally supportive, but there were no clear and consistent process to support and develop staff.

Managers did not ensure all staff were supported to develop through regular constructive clinical supervision and appraisal of their work. The service called their appraisal, professional development reviews (PDR). Only 15 out of the eligible 49 staff had a PDR in the last year.

Our findings

Although staff told us managers were open and they could go to them if they needed to talk, it was not clear how managers supported staff to identify any training needs and gave staff the opportunity to develop their skills and knowledge. The provider informed us there was a recognising deteriorating patient training for reception staff. However, none of the staff we spoke to had completed the training.

The clinical teams met every month to discuss issues such as risk issues that affect quality of service delivery and health and safety. There was a separate meeting for non-clinical staff including drivers.

Managers ensured that all new starters had a comprehensive induction. They carried out one month, three month and five month reviews for all new starters.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of depression, self-harm or suicide.

The service was part of the integrated learning review team, a multidisciplinary team of specialists across Medway, that met weekly to discuss and review patients who have been referred with multiple long term conditions, complex needs, people living with frailty, and needs that span across different agencies. The purpose of the meeting was to have a coordinated multiagency approach to ensure these patients received the best care and prevent a rapid decline.

The service held regular team meetings. There was a monthly clinical team meeting where clinicians from all disciplines met to discuss quality and service related issues. However, there were very limited patient safety conversations or how to improve outcomes for patients at this meeting.

Staff employed to drive doctors and staff to patient appointments met quarterly for formal discussion. The nurses met every month in an open forum, and this was not recorded.

The teams had a good working relationship with external teams, such as radiology and frailty teams, and other organisations such as addiction services. Staff told us they could refer patients directly onto the wards for admission.

Seven-day services

Key services were available seven days a week to support timely patient care.

MedOCC UTC operated a 24 hour service, seven days of the week. Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. If staff needed support, they could easily bleep psychiatric liaison team.

Health Promotion

Staff discussed with patients' ways to improve their health and wellbeing.

Our findings

Staff discussed with patients' ways to improve their health and they could refer patients to other services for example drug and alcohol services. However, there was very limited information around promoting healthy lifestyle and further support in reception area, including self-help materials.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

The service provided training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of the safeguarding training. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, staff did not always record patients' consent to treatment.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Although staff told us that they always sought consent before caring for or treating a patient, they did not always ensure that consent was clearly documented. Staff were not documenting consent to treatment in five out of 14 care records we reviewed.

Is the service caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were respectful and kind and were compassionate in the way they spoke to patients.

The service was extremely busy on the day of our inspection and the reception room was full. Although there were very limited interaction between staff and patients in the waiting area, carers and parents in the children waiting area told us staff had come to speak to them and also to apologise about the long waiting times.

We observed a member of staff asking a patient who had been standing for hours if they would like a chair. Patient informed staff they preferred to stand as they felt severe pains when sitting.

We observed staff caring for a patient who had a medical emergency at reception. Staff were discreet and responsive whilst caring for them. Staff asked patients and visitors to respectfully vacate the area while they supported the patient. The patient was shielded with a privacy screen while they were being attended to. Staff spoke to them in a kind and supportive way. However, people in waiting area could hear some of the conversation. Staff did not move the patient to a more private area.

All patients we spoke to said staff were kind and caring. One patient was very pleased with the outcome of the visit and had been there on previous occasions. Patients felt they received optimal care every time, although there was always a long wait to be seen.

Our findings

Staff followed policy to keep patient care and treatment confidential. Reception staff asked patients to confirm their names and date of birth without giving out all the details.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, patients who initially felt anxious and thought their condition was life threatening reported how staff had supported them and explained to them that their condition was manageable which put their minds at ease.

Staff told us that the service catered to people from a wide demographic and they always took time to understand and respond to people's personal, cultural and religious needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Most of the clinicians we spoke to reported they enjoyed working for the service because they were given enough time to do their jobs. Staff enjoyed getting to know the patients and also taking time to explain the patients care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. However, feedback could only be completed using a QR code which may exclude people who may not be up to speed with modern technology. Managers told us they were relaunching the patient satisfaction and feedback process to be more inclusive.

Staff had received huge praise for their caring attitude in the most recent patient satisfaction survey.

Is the service responsive?

Requires Improvement

Our findings

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The provider understood the needs of the local population and tailored services in response to those needs. The provider informed us they engaged with commissioners. However, the service had not submitted any key performance reports to the commissioners since May 2021.

The provider informed us that it was agreed between the CCG and the provider to suspend reporting of key performance indicators (KPIs) due to the pandemic. The provider reported a daily performance report was shared with the commissioners by the acute trust which included MedOCC performance. The provider also reported that there was a monthly Local A&E delivery board meetings where MedOCC performance was discussed with commissioners and system partners.

The service worked with the local ambulance to develop pathways, and ensured suitable patients were transported to the service where appropriate.

Managers informed us they met weekly with other key stakeholders including local charities and social care partners to ensure patients could access appropriate care and support via a multiagency approach.

Managers reported that one of their biggest challenges was the premises, which was impacting on service delivery, and had been registered as a risk corporately.

The service had 10 consultation rooms and there were plans to increase the number of rooms to 12 in the new build, so the teams could see more patients on time.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they met regularly with teams from the acute trust. Staff could bleep the psychiatric liaison service if they needed support.

Managers monitored the number of missed appointments. Managers told us they try to contact people who missed their appointment or inform their GPs. Although this was not always possible.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. The acute trust had two learning disability nurses and staff had easy access to them.

The service could easily access support from the community teams to provide care packages.

There was a plan in place to make the unit more dementia friendly in the new build.

The service had step-free access for wheelchair users and for people with mobility problems. There were disabled toilets available on the unit.

Our findings

Managers made sure staff and patients, loved ones and carers could get help from interpreters or signers when needed. Managers told us there was a third party agency who they could access 24 hours of the day, seven days of the week for translation and interpretation services.

However, there were no hearing loop for patients who had a hearing impairment and there were limited communication tools available. For example, easy read posters.

At the time of our inspection, we saw that the TV in the main waiting area was switched off, although people were waiting for hours to be seen.

Access and flow

The service was consistently in breach of the waiting times from referral to treatment and arrangements to admit, treat and discharge. However, people could access the service when they needed it.

The service was reporting long waiting times for people, including those who were on a prebooked appointment. There had been 1,031 reported waiting times breaches between November 2021 and January 2022, where patients had been waiting for over four hours before they were seen. We raised this following the inspection and the provider reported that they saw a total of 10,735 patients during this period, and around 10% of cases had the four hour performance target not been met.

The service reported that 3,984 patients had left the service without being seen in the last three months. Managers told us the teams would normally contact patients who did not wait or referred them back to their GPs for follow up.

Patients visiting the service were either on a prebooked appointment following an initial advice call with the NHS 111 service or were streamed on entrance to the department by staff from the acute trust. MedOCC did not accept walk in patients. About 60% of the reported patients that were seen daily were streamed via this process.

The A&E and the UTC operated a streaming model (Simple Triage Rapid Emergency Assessment Method) from 8am to 10pm. The streaming model involved a senior decision maker with specialist training who carried out a rapid triage of patients and directed them to the urgent treatment centre or other services where they could normally get care and treatment depending on their presentation. However, this process was not working effectively.

Although the service had a clear admission criterion for patients who needed urgent treatment and would be seen by them, the service did not ensure patients were receiving timely care and support. The service reported between August 2021 and February 2022, there had been 284 inappropriate patient referrals taken back to A&E, and a further 1,177 patients advised to attend the A&E. Some patients were waiting up to eight hours at MedOCC before they were sent to A&E. This meant that a patient's condition could deteriorate while they were waiting to be seen by a clinician. Patients who were sent to A&E were given a handover sheet which included a brief summary and specific instructions for medical investigation.

Patients we spoke to told us they were unhappy because they had waited in the service for up to one hour before they were sent to A&E.

Following the inspection, the provider reported that the 284 inappropriate referrals taken back to A&E account for 1% of the 26000 patients that were seen during this time period and the inappropriate referrals were mainly due to human factors.

Our findings

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, whilst patients could give feedback and raise concerns about care they had received there were limited options for them to do so.

Patients, relatives and carers knew how to complain or raise concerns. The service had a QR code at reception which patients could scan if they needed to make a complaint or give feedback. Staff told us patients could also call the customer care team if they needed to make a complaint. However, there were no patient feedback forms or complaints box and paper leaflets in reception area on how to make a complaint. Managers told us they were relaunching the feedback and complaints process.

Staff understood the policy on complaints and knew how to handle them. Staff told us they initially try to resolve any concern the complainant had, and if they decided they wanted to make a formal complaint they would support them to do so.

Staff could give examples of how they used patient feedback to improve daily practice. For example, patients had complained about poor customer care experience. This led to the customer care team undertaking training and a presentation to reception staff.

The customer care team had recently done a presentation to reception staff on how to acknowledge and respond to complaints, to ensure patients had a good experience following patient complaints.

Managers investigated complaints, identified themes and shared feedback from complaints with staff. Managers learned lessons from complaints. For example, the service now had a miscarriage pack following complaints from women attended the service following a miscarriage.

MedOCC UTC had received 39 complaints between September 2021 and February 2022. Of these, 35 were accepted and four of them rejected. Majority of the complaints were about the quality of care.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff

Leaders understood what the challenges of the service were and were taking steps to address them. Leaders told us some of the challenges such as the poor environment were not directly under their control but was a result of the contractual relationship between the service and the acute trust.

Our findings

Staff spoke very highly of their leaders said they were supportive, especially when the service was very busy and when they needed to deal with challenging patients. All the medical staff we spoke to were very complimentary of the medical director about how supportive, kind and understanding they were.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision of how they will provide optimal care for patients in the safest and most efficient way. Leaders could describe the strategy of how they will turn it into action which included developing staff and working with patients, families and other stakeholders. Managers informed us that their aspiration was to stabilise the service and resume normal operations after the impact of COVID-19, and also continue to build on new ways of working such as remote prescribing.

Leaders have developed a quality improvement action plan of how they would improve the service safety, effectiveness, responsiveness and patient experience which was being monitored and updated regularly.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke to felt they were respected, supported and valued by their managers and their colleagues. Leaders operated an open door policy and staff felt they could raise concerns without fear of retribution.

The service actively promoted equality and diversity. Staff had received training in diversity awareness.

There was a strong emphasis on the safety and wellbeing of staff. Staff reported a positive relationship between the senior leaders and the rest of the team.

Locum staff felt they were treated as part of the team even though they had full time employment elsewhere.

Governance

Whilst there was a governance process in place to provide oversight of quality and safety performance, we were not assured they were sufficiently robust in consistently maintaining standards in the urgent treatment centre.

There were concerns about some aspects of the service that needed clear plans for how to improve them. For example, the service was reporting a high number of patients who had been wrongly streamed to the UTC and were sent to the A&E department. It was not clear what actions that were being taken to address this. Additionally, most of the patients were waiting for hours before they were sent back. However, the service undertook a lot of audits including medicines audit which had clear actions for how they would address any concerns identified.

Our findings

Managers did not ensure staff received annual professional development review and there were no clear timeframes to address this. It was also unclear how managers ensured staff were supported to develop.

The clinical team meetings were not always patient focused. Although the quality of service delivery was a standing item on the agenda, leaders did not ensure all aspect of the service were working effectively.

Managers did not always ensure there were up to date revalidation certificates and appraisals on file for medical staff. In two of the three personnel files we reviewed, two of them were missing a revalidation certificate and up to date appraisal. One staff member did not have a DBS certificate on file.

Management of risk, issues and performance

Leaders did not ensure service level risks were managed effectively.

While there were processes in place to monitor and review all aspects of performance and identify areas of good practice and areas for improvement, leaders did not ensure staff were working in line with internal protocols and best practice to reduce risks. For example, the service had a plan to manage waiting times. This protocol, also known as the 'MedOCC Patient Surge Plan', required that the teams bleep the site manager to stop all streaming from the A&E department to the UTC when wait times exceeded three hours. Patients and the provider were reporting wait times of up to eight hours. It was not clear how this protocol was being implemented.

Managers told us there was a rapid review process for patients who were waiting for over one hour, as they were prioritised to be seen quickly. None of the staff including reception staff could explain how the rapid review process worked and what the time frames were for people to be seen and how they prioritised patients who were at risk of deterioration. Some staff members said it was two hours, while others said they were unsure if it was more or less than two hours.

The environment and IPC were on the risk register but there were no clear protocols on how the risks were being managed and actions the teams were taking to reduce such risks.

Information Management

The service collected reliable data and analysed it.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Although staff informed us they sometimes needed to navigate four different IT systems in order to complete certain tasks, which could be cumbersome.

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Our findings

The service involved patients, staff and external partners to explore ways to make the service more accessible and meet people's needs.

The service encouraged staff, patients and external partners to give feedback to understand how the service was performing.

There were weekly Medway integrated Locality review meetings attended by Medway GPs, CCGs, Medway community Healthcare, social services, the Kent and Medway Partnership trust and other key stakeholders where high risk patients care were discussed and planned. The information was then shared with the patients' GP who then discussed the plans and outcomes with them.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods.

Staff knew about improvement methods. The service leaders recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service.

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that patients are clinically assessed and seen on time in line with best practice and national guidelines. The provider must ensure that people are adequately monitored while they waited to minimise the risk of their health deteriorating (Regulation 12)
- The provider must ensure that the environment, including the toilets at the site, are clean and standards of cleanliness are maintained throughout the day (Regulation 15)
- The provider must ensure that adequate security processes are in place for entry to the department to ensure safety of patients and staff. The provider must ensure there are CCTVs in place to monitor people coming into the department (Regulation 15)
- The service must ensure that staff complete their mandatory training, including face to face training where applicable (Regulation 18)
- The service must ensure that the safeguarding alert system is working effectively, and that all staff are always aware of appropriate actions to take if there were concerns (Regulation 13)
- Managers must ensure all staff receive regular clinical supervision and appraisal, and that staff are supported to access specialist training (Regulation 18)
- The service must ensure that all aspects of its governance processes is robust and effective. Leaders must ensure that all service level risk are managed well and responded to in a timely way (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure that all records are completed thoroughly and kept up to date.
- The service should ensure that there is enough information including self-help and health promotion material available to patients and families.
- Staff should ensure consent to treatment is sought and recorded for patients.
- The service should ensure that medicines are stored according to manufacturer's instructions.

Our inspection team

The team that inspected the service comprised of three inspectors, one medicines inspector, one medicines inspection manager and a specialist advisor.

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 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment