St Mary's Urgent Care Centre (Vocare Limited)

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Mary's Urgent Care Centre (Vocare Limited) on 13 July 2017. Overall the service is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- Systems and processes were failing to identify all incidents and ensure that learning and outcomes were effectively shared to prevent the same incidents happening again. Opportunities to prevent or minimise harm were missed as there was insufficient oversight and monitoring of ongoing incidents and risks both at local and organisational level.
- There was insufficient attention to safeguarding children and vulnerable adults. We found that processes were not clearly defined or embedded.
- The provider demonstrated an effective recruitment system for substantive and agency staff. However, the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs had been inconsistent and there were periods of understaffing.
- The provider had insufficient assurances in place to demonstrate that people received effective care. This included a system to ensure clinicians were up-to-date with and following current evidence-based guidance and that regular reviews of clinical notes were undertaken.
- The provider demonstrated an understanding of the service's performance. However, it had failed to achieve some of its performance targets.
- There was limited evidence that clinical audit was driving improvement to patient outcomes.
- Staff had not received a formal appraisal necessary to enable them to carry out their duties although the provider demonstrated it had commenced one-to-one meetings with staff in preparation for an appraisal.
- On the day of the inspection we observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

Summary of findings

- Information about how to complain was available to patients and we saw that complaints had been handled in a timely manner and in line with national guidance.
- The provider had undertaken limited patient engagement to obtain the views of people who use the service.
- Although the service had an overarching organisational governance framework this had not been implemented adequately at a local or organisational level to ensure the delivery of good quality care and opportunities to prevent or minimise harm were missed.
- There had been a lack of clear management and clinical leadership and staff had not felt supported in their day-to-day roles. However, staff told us communication and engagement had improved since the interim management team had been in place.
- We saw evidence that the provider had complied with the Duty of Candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) and contacted patients potentially affected by recent breaches of the cold chain and those where there had been a delay in identifying a missed fracture.

The areas where the provider must make improvement are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

The areas where the provider should make improvement are:

- Consider the infection control lead undertaking enhanced training to support them in this extended role.
- Review the fire evacuation procedure to ensure all staff understand, and continue to understand, the plan in the event of a fire.
- Review auditory privacy at all points of patient access to the service.
- Review how patients with a hearing impairment would access the service.
- Consider providing patient literature in languages aligned to the identified patient demographic.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

Inadequate

The service is rated as inadequate for providing safe services and improvements must be made.

- Although there were policies and a system in place to record incidents, we found that these processes were failing to identify all incidents and ensure that learning and outcomes were effectively shared to prevent the same thing happening again. For example, a recurrence of a breach of the cold chain process and failure of the system to cross-check x-ray reports. Furthermore, opportunities to prevent or minimise harm were missed as there was insufficient oversight and monitoring of ongoing incidents and risks both at local and organisational level.
- There was no formal process in place to ensure patient safety alerts were shared with all staff.
- There was insufficient attention to safeguarding children and vulnerable adults. We found that processes were not clearly defined or embedded. The provider could not demonstrate that all clinical staff had received safeguarding children and adult training relevant to their role although staff we spoke with on the day demonstrated they understood their responsibilities to raise safeguarding concerns. There had only been three safeguarding children referrals and no safeguarding adult referrals in last 12 months. Over the course of a 12-month period it is unlikely that a service of this size and type would not have needed to make more safeguarding referrals.
- Staff who acted as a chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).
- The provider demonstrated an effective recruitment system for substantive and agency staff. However, the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs had been inconsistent. There were periods of understaffing or inappropriate skill mix to meet the requirements of the service. In addition, the provider relied heavily on agency GP and nursing staff.

Summary of findings

- The service had adequate arrangements to respond to medical emergencies which were co-ordinated with the hospital trust. However, its emergency preparedness policy was still in draft form.
- We saw evidence that the provider had complied with the Duty of Candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) and contacted patients potentially affected by recent breaches of the cold chain and those where there had been a delay in identifying a missed fracture.

Are services effective?

Inadequate

The service is rated as inadequate for providing effective services and improvements must be made.

- The provider had insufficient assurances in place to demonstrate that people received effective care.
- Although the clinicians we spoke with were aware of relevant and current evidence based guidance and standards the provider could not demonstrate an effective system to ensure all clinical staff were up-to-date or that these guidelines were followed.
- The provider demonstrated an understanding of the service's performance. However, it had failed to achieve some of its performance targets. For example, triaging and determining the care pathways for adults within the specified timeframes.
- There was limited evidence that clinical audit was driving improvement to patient outcomes.
- Staff had not received a formal appraisal necessary to enable them to carry out their duties although the provider demonstrated it had commenced one-to-one meetings with staff in preparation for an appraisal.
- The provider could not demonstrate that all staff had undertaken identified training in line with its policy which included safeguarding children, safeguarding adults, fire safety awareness, infection prevention and control and basic life support.

Are services caring?

Requires improvement

The service is rated as requires improvement for providing caring services.

Summary of findings

- On the day of the inspection we observed members of staff were courteous and helpful to patients and treated them with dignity and respect in both the Accident and Emergency department and the Urgent Care Centre.
- We observed that the layout of the reception areas at both the point of entry to the service in A&E and within the centre meant it was possible that conversations could be overheard by patients seated in the waiting area. Reception staff told us if a patient wanted to discuss a sensitive issue or appeared distressed they could offer them a private room to discuss their needs.
- The provider had not considered how patients with a hearing impairment would access the service as there was no hearing loop.
- Feedback from patients was mixed and we saw that 58% of patients would be extremely likely to recommend the service. Four out of seven comment cards received were positive about the service experienced.

Are services responsive to people's needs?

The service is rated as good for providing responsive services.

Good

- The facilities within which the service was operating was limited for space. However, access to the premises was via a patient ramp and there was an automatic door and accessible toilet facilities available. We found that the consulting rooms were equipped to treat patients and meet their needs.
- A chaperone service was available and advertised throughout the centre and staff we spoke with on the day understood their role as a chaperone.
- Patients had access to an interpreting service and all staff we spoke with knew how to access this.
- Information about how to complain was available to patients and we saw that complaints had been handled in a timely manner and in line with national guidance.
- Information for patients about the services was available but was not easily accessible by some service users. For example, the provider had identified a significant number of Arabic and Spanish-speaking patients but information was only available in the English language.

Are services well-led?

The service is rated as inadequate for being well-led.

Inadequate

Summary of findings

- Although the service had an overarching organisational governance framework this had not been implemented adequately at a local or organisational level to ensure the delivery of good quality care and opportunities to prevent or minimise harm were missed.
- The service had been lacking a clear management and clinical leadership structure and staff had not felt supported in their day-to-day roles. However, staff told us that communication and engagement had improved since the interim management team had been in place.
- Although the service had comprehensive organisational policies and procedures these were not always location-specific and it was unclear how agency staff had access to them.
- There was evidence of some governance, including with stakeholders, and staff meetings but these had not been regularly held. The provider had recently revised the format of its staff bulletin to include incidents, complaints, compliments and patient safety alerts to enable better communication to staff.
- The provider had undertaken limited patient engagement to obtain the views of people who use the service.

Summary of findings

What people who use the service say

The provider gathered patient feedback through the NHS Friends and Family Test (FFT). We were told that FFT surveys were given out ad hoc in the Urgent Care Centre and so the provider were not able to confirm how many had been distributed. Data showed that between May 2016 and May 2017 there had been 115 surveys returned. Results showed that 58% (67 surveys) would be extremely likely to recommend the service and 23% (27 surveys) would be extremely unlikely to recommend the service. The provider had not undertaken any other form of patient engagement.

We received seven patient Care Quality Commission comment cards, four of which contained positive comments about the service experienced. Comments included that it was a great service with a high level of professionalism and staff treated them with dignity and respect. Three of the comment cards contained negative comments all of which related to the waiting time to be seen.

We did not have the opportunity to speak with any patients in the centre during our inspection.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Action the service SHOULD take to improve

- Consider the infection control lead undertaking enhanced training to support them in this extended role.
- Review the fire evacuation procedure to ensure all staff understand, and continue to understand, the plan in the event of a fire.
- Review auditory privacy at all points of patient access to the service.
- Review how patients with a hearing impairment would access the service.
- Consider providing patient literature in languages aligned to the identified patient demographic.

St Mary's Urgent Care Centre (Vocare Limited)

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to St Mary's Urgent Care Centre (Vocare Limited)

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

The UCC service is provided by Vocare Limited who were awarded the contract in April 2016 following a procurement and tender process. The service had previously been run by the trust. Vocare, founded in 1996, is a national provider with headquarters in North East England and provides urgent care services to approximately nine million patients across the United Kingdom through urgent care centres, GP out-of-hours services and the NHS 111 services.

St Mary's UCC is managed and overseen by Vocare's London regional management structure headed by a regional director within the national corporate organisational structure. The local management team in the centre comprises a clinical director, lead nurse, and service operational manager. We were told the week prior to the inspection that the clinical director had resigned with immediate effect and the service operational manager had resigned and would not be available on the day of the inspection. The lead nurse position had been vacant since April 2017. We were informed by the provider that they had seconded to the centre, with immediate effect, an operational lead and lead nurse who had been part of the mobilisation of the service in April 2016. The secondment to the service would be full-time and for an initial period of three months. The local clinical director post would be covered by the Deputy Organisational Medical Director. The CCG told us they had been informed of this interim management structure arrangement. All interim staff were present at the inspection. The London regional director was not available at the inspection due to pre-planned leave.

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

Detailed findings

Reception at the point of entry to the service (A&E department) and paediatric initial assessment ('streaming') is currently sub-contracted to the hospital trust who provide these functions on behalf of the provider.

The provider is operating within a commissioned clinical and operational model for patients attending the UCC which requires patients to initially present to the A&E department where they are 'streamed' by a clinician to determine their care pathway. If the pathway is to be seen at the UCC then the patient is given an appointment and directed to separately located premises. The UCC is accessible by both an internal and external route within the hospital trust estate. The inspection team walked the patient journey and found that dependent on pace of walking, ambulatory capacity and whether an internal or external route had been chosen this could take between 10 and 30 minutes.

The patient activity at the UCC is approximately fifty-five thousand patients per year.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share information. These included the commissioners (Central London CCG) and Imperial College Healthcare NHS Trust who had been sub-contracted by the provider to deliver reception services and paediatric initial assessment at the point of entry to the service through the Accident & Emergency department.

The commissioners advised us that they had undertaken some recent announced and unannounced visits to the centre as part of contract quality and performance monitoring. A visit undertaken on 26 June 2017 highlighted some concerns in relation to cold chain management, safeguarding, clinical leadership, workforce capacity, monitoring x-ray reports and the organisational escalation policy. The provider disclosed full details of these visits and actions undertaken to date to the Care Quality Commission the week before the inspection.

We carried out an announced visit on 13 July 2017.

During our visit we:

- Spoke with a range of staff including the interim management team, recruitment, duty doctors, nurse practitioners and reception staff.
- Spoke with Imperial College Healthcare NHS Trust A&E staff.
- Observed how patients were greeted on arrival at the urgent care centre.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Inspected the facilities, equipment and premises.
- Reviewed a wide range of documentary evidence including the service contract, policies, written protocols and guidelines, recruitment and training records, significant events, patient survey results, complaints and performance data.
- Reviewed a sample of anonymised treatment records of patients.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Inadequate

Are services safe?

Our findings

Safe track record and learning

There were policies and a system in place to record all categories of incident on an electronic risk management software tool (Datix) However, we found that systems and processes were failing to identify all incidents and ensure that learning and outcomes from incidents identified were effectively shared to prevent the same thing happening again. Furthermore, there was insufficient oversight and monitoring of ongoing incidents and risks at both local and organisational level.

- The provider submitted a range of corporate incident and adverse event reporting policies and told us the process to report and record an incident was through Datix. However, not all of the staff that we spoke with on the day were aware of this process but said they would raise any incidents to a clinical or service lead.
- The provider told us that feedback to staff on incidents was by the way of a staff newsletter or on the provider intranet. However, not all staff we spoke with on the day had received feedback on recent incidents, which included two recent breaches of the cold chain (a system of storing medicine requiring refrigeration within a recommended temperature range of +2 to +8°C). Furthermore, agency staff did not have access to the intranet portal.
- We saw evidence that for the period June 2016 to May 2017 the provider had recorded 173 significant events through Datix and an overview provided outlined action taken, investigation details, lessons learned and outcomes.
- The provider held a risk register and we saw that all identified risks had been assessed to define the level of risk by considering the category of probability against the category of impact on the service. All risks had been allocated a RAG (red, amber, green) rating based on this assessment.
- Immediately prior to the inspection the provider had shared with us an ongoing incident regarding a breach in their system of cross-checking patient x-rays following radiologist review to ensure the appropriate diagnosis had been made by its clinicians at the time of consultation and that any missed fractures were identified and follow-up treatment arranged. We noted that the provider had added this to its risk register on 7 March 2017 and estimated a potential backlog of two months. The risk had been allocated a red rag rating. The risk register indicated that there had been no further follow-up until 1 June 2017 when a meeting was held to review the backlog, the process and how to improve. A further entry on 28 June 2017 noted that no progress had been made and additional clinical and operational support had been initiated to process the backlog. On the day of the inspection the provider told us it had addressed some of the backlog and April, May and June were up-to-date. However, an ongoing audit had identified that there was a potential backlog of approximately 1500 x-ray reports requiring cross-checking from the period May 2016 to March 2017.
- We saw evidence that the provider had complied with the Duty of Candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) and contacted patients who had potentially been affected by recent breaches of the cold chain and those where there had been a delay in identifying a missed fracture.

The provider shared an electronic register of alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and we saw evidence that recent alerts had been added and action taken to those relevant to the service. However, these had not been shared consistently with substantive and agency staff at the UCC. Staff we spoke with told us they had not received any recent alerts. We saw the interim management team had revised the format of its staff bulletin and the July 2017 issue, which had been sent out to staff on the day of our inspection, included hyperlinks to recent alerts.

Overview of safety systems and processes

Systems and processes in place to minimise risks to patient safety were not clearly defined and embedded.

- Prior to the inspection the provider sent its organisation's safeguarding children and safeguarding adult policies. However, these did not include local safeguarding arrangements, for example local authority contact details. However, we did observe safeguarding contact details were displayed in consultation rooms. The day after the inspection the provider sent a combined safeguarding adults and children procedure for the centre which was in the process of being ratified for circulation. We noted this contained the local

safeguarding process, local contact numbers and contained guidance which included domestic abuse, modern slavery, honour-based violence/abuse, forced marriage, female genital mutilation (FGM), human trafficking and violent extremism.

- There were interim safeguarding children and safeguarding adults leads in place due to recent staffing changes. However, not all staff we spoke with on the day knew who the leads were.
- There had only been three safeguarding children referrals and no safeguarding adult referrals in last 12 months. Over the course of a 12-month period it is unlikely that a service of this size and type would not have needed to make more safeguarding referrals. The management team told us safeguarding referrals were made through local processes and also recorded on its Datix system.
- Staff we spoke with demonstrated they understood their responsibilities to raise safeguarding concerns. The provider had links with nominated safeguarding leads within the CCG but at the time of our inspection the provider had not developed any links or partnerships with local safeguarding boards.
- We reviewed training records and found none of the salaried GPs identified on the training matrix had a record of receiving safeguarding children level three training and only five out of 17 GPs identified as sessional GPs had a record of receiving this level of training. We found that from eight nurse practitioners identified on the training matrix only three had received safeguarding children level three training in line with the provider's policy. We saw that nine out of 11 non-clinical staff had received safeguarding children level two training and safeguarding adult training relevant to their role. All non-clinical staff, except for one, was recorded as having Prevent (preventing violent extremism) training but none of the clinical staff.
- We saw patient information leaflets available in the waiting on 'how to recognise if your child is seriously ill.' This had been produced in conjunction with the UK Sepsis Trust.
- A notice in the waiting room and consulting rooms advised patients that chaperones were available if required. We saw evidence that all staff who acted as a chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff we spoke with on the day understood their role as a chaperone.

The provider maintained appropriate standards of cleanliness and hygiene.

- The hospital trust cleaning team was responsible for cleaning the urgent care centre and we observed the premises to be clean and tidy. The interim nurse lead was the infection prevention and control (IPC) clinical lead and had undertaken on-line IPC training but no enhanced training to support them in this role. We saw that all non-clinical staff had undertaken on-line IPC training but there was no record of any of the salaried GPs, only one of the sessional GPs and only two of the nurse practitioners having received training.
- An IPC audit had been undertaken in May 2017 and we saw evidence that action was taken to address any improvements identified as a result. For example, to ensure sharps bins were appropriately labelled. We observed that all sharps bins were appropriately labelled on the day of the inspection.
- There was an IPC policy and staff had access to this on the organisation's intranet. However, agency staff told us they could not access this portal. All staff we spoke with knew the location of the bodily fluid spill kits and had access to appropriate personal protective equipment when handling specimens at the reception desk.
- We observed that each consulting room had information displayed on good handwashing techniques, how to deal with a sharps injury and was well equipped with personal protective equipment and waste disposal facilities.

The provider had an effective recruitment system in place which was managed centrally. The national head of recruitment was present at the inspection and we were able to access the recruitment database to review files for salaried and sessional clinical and non-clinical staff based at the UCC. We randomly selected and reviewed three personnel files of a substantive GP, nurse and non-clinical staff member and two agency files of a doctor and nurse. We found appropriate recruitment checks had been undertaken prior to employment for all staff. For example, interview notes, proof of identification, references, qualifications, registration with the appropriate professional body, inclusion on performer's list,

appropriate indemnity and the appropriate checks through the Disclosure and Barring Service. The provider had a mechanism in place that clinical staff could not be added to a rota until all pre-recruitment paperwork had been signed off.

Medicines Management

On the day of the inspection we found the arrangements for managing medicines, including emergency medicines and vaccines, in the service minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Prior to the inspection the provider advised us there had been two recent incidents regarding a breach of the cold chain (a system of storing medicine requiring refrigeration within a recommended temperature range of +2 to +8°C) which had been identified on a quality visit by the provider's commissioners. We saw that after the first breach a new vaccine refrigerator had been procured and a system put in place for the reception team to monitor the temperatures in line with guidance. Unfortunately this had not been cascaded adequately to staff working in the evening and at the weekend and a second cold chain breach occurred. Staff we spoke with on the day of the inspection told us they had previously been unaware of the significance of the minimum and maximum temperatures (+2 to +8°C) and had recorded temperatures in excess of +8°C without escalating this as a concern. There had been no secondary oversight of the process. At the inspection we spoke with staff and they demonstrated a good knowledge of the cold chain, including when vaccines were delivered, and we observed notices on the refrigerator advising staff to escalate to a manager if the temperatures were out of the specific ranges. The interim lead nurse was providing a secondary oversight of this process. On the day of the inspection we observed a dedicated vaccine storage refrigerator with built-in thermometer and we saw evidence that the minimum, maximum and actual temperatures were recorded daily. There was a secondary thermometer available. We saw that the refrigerator was appropriately stocked and all medicines were within their expiry date.
- The service did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- Blank printer prescription forms were securely stored and there was a system in place to monitor and track their use. All prescriptions were removed from consulting rooms when not in use.
- Patient Group Directions (PGDs) were used by nurses to supply or administer medicines without prescriptions. PGDs in use had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance.
- We saw that prescribing was in line with the local north-west London integrated formulary. The centre had carried out two single-cycle audits to ensure prescribing was in line with best practice guidelines. For example, we saw a urinary tract infection audit had been undertaken in June 2017 to evaluate the diagnosis of uncomplicated urinary tract infections and to assess antibiotic prescribing.
- There was a system in place for ordering medicines in line with the local urgent care formulary which included 'to take out' (TTO) medicines for patients (pre-packed and pre-labelled medicines). These were stored securely and within their expiry dates. There was a record maintained of medicines dispensed to patients.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- The premises were managed by the hospital trust's facilities management team. We were able to inspect various maintenance schedules and risk assessments to monitor safety of the premises such as Legionella (Legionella are bacteria that can contaminate water systems in buildings) which had been undertaken in October 2016.
- The hospital trust had organised a fire risk assessment of the UCC in January 2017 and we saw evidence that action had been taken to identify some of the issues raised, for example portable appliance testing and the removal of items obstructing an escape route.
- We saw evidence that the fire alarm warning system was tested on a weekly basis and emergency lighting on a monthly basis. The provider had a fire and evacuation policy which outlined the location of the fire assembly location point. However, the majority of staff we spoke with did not know where this was. There was reference in the policy to the responsibilities of the nominated fire marshal but it did not name the local fire marshal and

staff were unclear on who was nominated in this role. Staff confirmed that there had been no organised fire evacuation drill of the UCC by the provider or a co-ordinated evacuation with the hospital trust. All non-clinical staff had undertaken fire awareness training. However, not all substantive GPs and nurse practitioners had a record of training.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. We saw evidence that both portable appliance testing and clinical equipment calibration had been undertaken in July 2017.

The arrangements for planning and monitoring the number of staff and the mix of staff needed to meet patients' needs had been inconsistent. The provider told us they had experienced difficulty recruiting substantive staff and had a high reliance on agency staff. The provider told us that approximately 60% of its entire workforce were agency staff. A further breakdown showed that 37% of GPs and 67% of nurses were agency staff. The provider utilised a combination of GPs, emergency department doctors, advanced nurse practitioners (ANPs), nurse practitioners (NPs), emergency nurse practitioners (ENPs) and emergency care practitioners (ECPs) to deliver the service. A range of staff we spoke with on the day indicated that there were times of understaffing which impacted on the delivery of the service and created a backlog of patients at the 'streaming' stage within A&E and awaiting treatment within the UCC.

To assess the potential impact on patient care we reviewed staffing rotas for a six-month period from February to July 2017 and saw there were gaps in some shifts of the full complement of skill set needed to deliver the service. We also reviewed email dialogue between the provider, the commissioner and the hospital trust when staffing issues had been raised. We saw that some staffing shortages had been raised as incidents by the hospital trust and the provider had added recruitment and staffing to its risk register as an ongoing risk. We asked the provider to demonstrate how it responded when service demand exceeded the resources available to safely manage cases requiring 'streaming' and those requiring assessment and management in the UCC. The provider told us that staff would be moved and flexed across the service and we saw email communication where this contingency had been activated. However, it was unclear whether this had been done consistently to ensure delivery of the service and patient safety. It was not possible to explore this further as key members of the management team had since resigned.

The provider told us that since the interim management team had been in-situ, and in response to concerns raised by the commissioners in relation to staffing, it had drafted a service escalation policy which outlined trigger points and actions to take in the event of capacity not meeting demand through both fluctuations in the service and unexpected staff absence. The provider informed us they had put various mechanisms in place to improve rota management which included a dedicated rota manager for the UCC, regular rota meetings to ensure the appropriate skill mix were allocated shifts and an extension of the rota preparation process to three months in advance to better enable the early identification of potential capacity issues. In the long-term the provider told us they were looking at rates of remuneration and incentive schemes in its recruitment campaign to attract substantive staff.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements in place to respond to emergencies and major incidents.

- The UCC was located within the hospital trust estate and operated within its emergency response protocol through the standard crash call telephone number. There was a resuscitation trolley within the UCC which was easily accessible and stocked identically to those within the hospital trust to ensure consistency. We saw there was a defibrillator available and oxygen with adult and children's masks.
- All equipment and medicines on the resuscitation trolley were checked weekly and we saw evidence of a check list.
- The provider could not demonstrate from its training records that all staff had undertaken basic life support training.
- Prior to the inspection the provider sent us its organisational business continuity and disaster plan for major incidents such as power, telephony and IT failure. This was not specific to the UCC. During the inspection the provider told us they had engaged a business continuity consultant who had drafted an emergency preparedness, resilience and response policy in liaison

with the hospital trust which was location-specific. The provider sent us the draft policy which we were told was due to be signed off at the end of July 2017 by the organisation's management team.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians we spoke with on the day were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and these were available on the provider intranet and the clinical system including prescribing guidelines. However, the provider did not have an effective system in place to ensure all clinical staff were up-to-date or that these guidelines were followed. The lack of assurance that clinical updates and NICE guidelines were being displayed within the centre and/or disseminated to staff had been added to the provider's risk register on 1 March 2017. An update added on 10 July 2017 indicated that this was still on-going.

Management, monitoring and improving outcomes for people

The urgent care centre was contractually required to meet a range of quality and performance indicators and provide performance reports to the clinical commissioning group (CCG). Performance figures reported to the CCG showed the following:

- 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 with a target of 95%. The provider sub-contracted the hospital trust to undertake paediatric initial assessment at the point of entry to the service through the A&E department. Data for the period June 2016 to May 2017 showed that the target for children had been met each month with achievement between 99% and 100%. However, the target for adults had not been met for nine consecutive months from June 2016. Achievement ranged between 39% and 82%. The provider had achieved the target for March and April 2017 but this had dropped again to 91% for May 2017.
- The service had a target that, after the definitive clinical assessment had begun then the care must be completed within 4 hours in at least 95% of cases seen in the urgent care centre. Data for the period June 2016 to May 2017 showed that the service had met this target for 10 out of 12 months with achievement ranging from 94% to 99%.
- The service had a target that a minimum of 95% of patients would have an episode of care report to the GP within 48 hours of discharge of the patient. Data provided for a three-month period (April to June 2017) showed that this target had not been met for patients with a GP. Data provided showed achievement to be 93% in April, 88% in May and 91% in June.
- All patients presenting to the Urgent Care Centre (UCC) with a suspected fracture had an x-ray undertaken by the hospital trust which was then interpreted by a UCC clinician and a diagnosis and appropriate management provided at the time of consultation. All x-rays were subsequently reported by the hospital trust radiologist and the UCC cross-checked the x-rays to ensure the appropriate diagnosis had been made by its clinicians and that any missed fractures were identified and follow-up treatment arranged. The provider was failing to ensure an effective and timely process in line with their operating procedure. The provider told us they had identified that a potential backlog of approximately 1500 x-ray reports required cross-checking from the period May 2016 to March 2017.
- During our inspection we asked the provider to demonstrate the current system in place to cross-check x-rays. We saw on its single database that all x-rays undertaken in July 2017 had been reviewed. We reviewed a selection of patient notes to evidence that appropriate action had been taken and found that patient care and recording had been appropriate. The provider told us it had reviewed and refined the process which was being overseen by the interim management team.

The provider had a system in place for the assessment and audit of clinical note taking which included guidance and a toolkit. We reviewed three assessments for GPs and one for a nurse practitioner and found that these were satisfactory. However, there was no schedule maintained of who had undertaken a review, when and the frequency of reviews. We noted that the inability to maintain notes reviews due to lack of appropriately trained staff had been added to the provider's risk register on 1 March 2017. The risk register indicated that this concern was still on-going at the time of the inspection.

The lack of assurance around awareness of clinical audit and concerns that there had not been any undertaken was added to the provider's risk register on 7 March 2017. The risk register indicated that there had been no progression

Inadequate

Are services effective?

(for example, treatment is effective)

at the time of our inspection. However, we saw that the provider had undertaken two single-cycle antibiotic prescribing audits for symptoms of sore throat and urinary tract infections in May and June 2017 respectively and two single cycle audits relating to children not attending the UCC when an appointment had been made from the 'streaming' process and safeguarding note taking.

Effective staffing

Although the provider had comprehensive policies and procedures in place outlining the processes to deliver a programme of induction, training and appraisal necessary to enable staff to carry out their duties safely this was not adequately managed or documented:

- The provider had a selection of induction paperwork and check lists for all newly appointed clinical and non-clinical staff which covered the first week and month of induction. In addition we saw evidence of group induction sessions for nurses. However, we found gaps in staff records and the provider was unable to verify that all staff had received an induction. Furthermore, some staff we spoke with on the day told us they had not had an induction. The interim management team had identified gaps in the recording of induction for its reception staff and had re-sent the induction slides to its reception team as a refresher.
- The provider had a selection of appraisal paperwork for its clinical and non-clinical staff. However, the interim management team confirmed that none of the clinical and non-clinical staff who had been at the centre for more than a year had undertaken a full appraisal. However, they had commenced one-to-one meetings with staff in preparation for an appraisal. We saw that some of these were documented and some were informal. The nursing staff we spoke to on the day told us they had received a recent one-to-one meeting.
- The provider had identified a range of training for all staff which included safeguarding children and adults, basic life support, fire safety awareness, infection prevention and control, equality and diversity and information governance. The provider had recognised nationally that its recording of training was inconsistent and was in the process of capturing all local training into a centralised training compliance matrix so it could manage and oversee training nationally and be alerted to when updates were required. At the time of the inspection the provider was unable to accurately demonstrate training achievement at the centre. After the inspection the provider sent us the most current training schedule. This indicated there were gaps in training for clinical staff in safeguarding, basic life support, fire safety awareness, infection prevention and control, equality and diversity and information governance. Some staff we spoke with told us that any training they had undertaken had been done in their own time and there was no protected time for training.
- The provider maintained a skills competency overview of GPs and nurses (both substantive and agency) which included minor injury, minor illness, plastering, suturing, x-ray interpretation and IRMER (Ionizing Radiation (Medical Exposure) Regulations 2000 training which the provider used to ensure staff had the appropriate skill set and training to undertake a role.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system.

- The service shared relevant information with other services. Where patients had used the services, there was a system in place to send a report by 8am the day following the consultation to a patient's GP detailing the care that they received.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred.
- Patients had access to the hospital trust diagnostics services for x-rays 24-hours a day. Results were interpreted by the UCC clinicians and a formal report was provided by the hospital trust radiologist. However, the provider had a significant back-log in the cross-checking of these reports.

Consent to care and treatment

Staff demonstrated they sought patients' consent to care and treatment in line with legislation and guidance.

- Staff we spoke with on the day demonstrated they understood the relevant consent and decision-making requirements of legislation and guidance, including the

Inadequate

Are services effective?

(for example, treatment is effective)

Mental Capacity (MCA) Act 2005. Although the provider could not demonstrate a record of staff having undertaken MCA training, some clinical staff we spoke with on the day told us they had done training.

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

As a Urgent Care Centre (UCC) the service did not have the continuity of care to support patients to live healthier lives in the way that a GP practice would. Patients typically attended the service with acute episodes of minor illness or injuries requiring urgent attention. However, staff told us they were committed to the promotion of good health and patient education. Healthcare promotion advice was available in the waiting room.

Some patients attended the UCC with exacerbations of long-term conditions or conditions which could readily be treated in general practice. The team discussed the challenge of transient patients in the area who were not registered with a local GP were using the service as their primary medical advice. Staff encouraged patients to register with a GP and we saw leaflets on reception which provided guidance and information on how to register with a GP.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

On the day of the inspection we observed members of staff were courteous and helpful to patients and treated them with dignity and respect in both the Accident and Emergency (A&E) department and the Urgent Care Centre (UCC).

In the A&E department we observed that:

- The reception team sat behind a glass reception cubicle with full visibility of the waiting area.
- There was a separate designated children's waiting area which was decorated and equipped in a child-friendly manner.
- The clinician responsible for 'streaming' (initial assessment) sat to the left-hand side of the reception area within the seated waiting area which did not afford any auditory privacy. The provider told us the hospital trust were undertaking a reorganisation of the A&E reception and it was anticipated a separate room would then be provided.

In the UCC we observed that:

- The reception team sat behind a glass reception cubicle with full visibility of the waiting area.
- The waiting area was small and seating was close to the reception cubicle and so it was possible that conversations could be overheard by patients seated in the waiting area. Reception staff told us if a patient wanted to discuss a sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- There was no hearing loop available.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

We received seven patient Care Quality Commission comment cards, four of which contained positive comments about the service experienced. Comments included that it was a great service with a high level of professionalism and staff treated them with dignity and respect. Three of the comment cards contained negative comments all of which related to the waiting time to be seen.

Patient feedback was gathered through the NHS Friends and Family Test (FFT). For the period May 2016 to May 2017 there had been 115 surveys returned. Results showed that 58% (67 surveys) would be extremely likely to recommend the service and 23% (27 surveys) would be extremely unlikely to recommend the service. Written comments received on the survey for those patients who would be extremely likely to recommend the service included efficient and through service and friendly and helpful staff. Comments received from patients who would be extremely unlikely to recommend included long wait times. The provider had not undertaken any other form of patient engagement.

We did not have the opportunity to speak with any patients in the centre during our inspection.

Care planning and involvement in decisions about care and treatment

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. Clinical and non-clinical staff we spoke with on the day knew how to access these services.
- Notices and patient information leaflets were available in the waiting room about the services provided by the urgent care centre and how to access a number of support groups and organisations. However, these were not available in any other languages.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service was responsive to patients' needs in a variety of ways:

- The Urgent Care Centre (UCC) was signposted around the hospital both internally and externally and was accessible to patients with mobility issues in that there was a ramp and an automatic door leading to the main entrance.
- The waiting area was small and it was possible that at busy periods there would not be enough seating especially if patients had prams. The waiting area was fully visible from reception.
- Patient toilets, which included accessible facilities were available as well as a baby changing area.
- Interpreter services were available for patients whose first language was not English. Data provided for a three month period (April and June 2017) showed that interpreters had been accessed 23 times of which 43% required an Arabic interpreter and 17% a Spanish interpreter. The provider told us that these findings were in keeping with previous usage. However, patient literature and information including a leaflet given at the time of assessment in the A&E department which included guidance on what to do for worsening symptoms and directions to the UCC was in English. However, we did observe that the hospital trust estate had Arabic signage in place outside A&E.
- Staff in the UCC told us that they had access to the British Red Cross Emergency Multilingual Phrasebook which contained the most common medical questions and statements in a range of languages which could enable a medically qualified member of staff to make an initial assessment while an interpreter was contacted. Several members of the team were multi-lingual.
- A chaperone service was available and advertised throughout the centre.

Access to the service

The UCC offered care for walk-in patients with minor illness and injuries that needed urgent attention and was open 24 hours a day, seven days a week including bank holidays. Patients were able to access the service directly by self-presenting, or from their own GP or after contacting NHS 111 (NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs). The service was provided primarily for patients living in north-west London, but there were no restrictions to access, and the service was utilised by patients transiting through the area via one of the major transport hubs and a significant number of homeless patients. No patients were registered at the service as it was designed to meet the needs of patients who had an urgent medical concern but did not require accident and emergency treatment, such as non-life threatening conditions.

The provider was operating within a commissioned clinical and operational model for patients attending the UCC. Access to the service was through A&E which was located within St Mary's Hospital. Patients would present to reception and details such as name, date of birth, address and a brief reason for attending were recorded on the computer system. There were systems in place to determine any 'red flags' which might mean the patient needed to be seen by a clinician immediately. Reception staff we spoke with gave some examples which included chest pain, shortness of breath and severe blood loss. Patients were 'streamed' by a UCC clinician to determine their care pathway. At the time of our inspection paediatric 'streaming' was being undertaken by the hospital trust. There was a separate child-friendly waiting area. If the pathway was to be seen at the UCC then the patient would be given the next available appointment and directed to the centre which was accessible by both an internal and external route within the hospital estate. The patient journey, dependent on pace of walking, ambulatory capacity and whether an internal or external route had been chosen, could take between 10 and 30 minutes. The reception team at A&E gave patients directions to the UCC and what to do for worsening symptoms. However, these were only printed in the English language. The provider told us that if patients had not presented to the UCC 10 minutes prior to their appointment then they would telephone them.

We reviewed patient activity data for a three-month period (April, May and June 2017) during which time 17,392 patients presented to the service. We found:

- April 2017: 5737 cases presented to the service which equated to an average daily attendance of 151. Of these, 5195 were aged 16 and above and 70% were streamed

Good

Are services responsive to people's needs?

(for example, to feedback?)

to the UCC and 23% to A&E. There were 542 patients aged under the age of 16. Of these, less than 5% were streamed to the UCC and 95% were given an A&E referral.

- May 2017: 5910 cases presented to the service which equated to an average daily attendance of 153. Of these, 5277 were aged 16 and above and 60% were streamed to the UCC and 22% to A&E. There were 633 patients aged under the age of 16. Of these, 8% were streamed to the UCC and 91% were given an A&E referral.
- June 2017: 5745 cases presented to the service which equated to an average daily attendance of 146. Of these, 5261 were aged 16 and above and 64% were streamed to the UCC and 26% to A&E. There were 484 patients aged under the age of 16. Of these, 5% were streamed to the UCC and 94% were given an A&E referral.

Listening and learning from concerns and complaints

There was a system in place for handling complaints.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for urgent care centres in England.
- We saw that information and a complaints form was available in the waiting area to help patients understand the complaints system.
- The provider's website included the complaint policy and how to feedback complaints and concerns by telephone, email and post.
- We saw that the provider shared complaints received with the commissioner's in its monthly quality report.

All complaints were logged on an electronic risk management software tool (Datix). The provider had recorded 52 complaints between 1 June 2016 and 31 May 2017. From those we reviewed we saw that patients had received a written response, with details of the Ombudsman's office provided in case the complaint was not managed to the satisfaction of the patient.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The provider had recently revised its corporate vision, mission and values and were in the process of cascading these to staff at the centre. It shared its mission statement which was 'to be the urgent healthcare and partner or choice for the NHS, with a range of services which will allow them to provide better clinically-led, evidenced-based, innovative and sustainable services for patients'.

Governance arrangements

Although the service had an overarching organisational governance framework this was not implemented adequately at a local or organisational level to ensure the delivery of good quality care and opportunities to prevent or minimise harm were missed. In particular we found systems and processes were failing to ensure:

- An effective process to cross-check x-rays. There was no accurate reconciliation of all patient x-rays, there was no effective clinical review of all x-rays following receipt of radiologist's clinical findings to ensure missed fractures were identified, there was no effective recall of all patients with missed fractures to ensure appropriate management was initiated and there was a backlog of in excess of 1,500 x-rays pending review clinical review.
- An effective response when the back-log of xray reporting was identified.
- An effective system and process to ensure learning and outcomes from incidents and patient safety alerts were effectively shared with all staff.
- A clearly defined and embedded safeguarding children and adult system which included reporting, staff training and engagement with safeguarding agencies.
- A system of planning and monitoring the number of staff and mix of staff needed to meet patients' needs and the requirements of the service.
- An effective system to ensure that staff, including sessional staff had access to clinical and organisational policies.
- An effective system to ensure that staff, including sessional staff, had had training appropriate to their roles.
- An effective system to ensure clinicians were up-to-date with and following current evidence-based guidance and that regular note reviews were undertaken.
- A system of clinical audit to drive improvement in patient outcomes.

Some staff we spoke with told us there had been limited clinical supervision due to no clear leadership and the absence of a lead nurse role for a number of months. Policies and procedures were available on the provider intranet but agency staff did not have access to this portal.

The provider acknowledged that its systems and processes had failed to alert senior staff on an organisational level to these issues. However, we saw evidence that the interim management team had started to address these issues at a local level.

Leadership and culture

The provider had been open and transparent prior to the inspection and shared with us issues identified by its commissioners during some announced and unannounced quality and performance visits. The provider told us it was working in collaboration with the commissioners on addressing the issues identified which included cold chain management, safeguarding, clinical leadership, workforce capacity, monitoring x-ray reports and the organisational escalation policy.

On the day of the inspection the provider shared with us its challenges since mobilisation of the service which included recruitment, workforce capacity, skill mix, high reliance on agency staff, limitations of the premises and associated patient experience, lack of strong clinical and managerial leadership and the recent resignations of two key members of the centre's management team. The latter had necessitated the secondment of an interim management team who were present at the inspection.

Staff we spoke with told us there had been a lack of clear management and clinical leadership and staff had not felt supported in their day-to-day roles. In addition, there had been limited staff meetings and poor communication. However, staff told us communication and engagement had improved in the short time since the interim management team had been in place.

We found that the provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that patients had been contacted following outcomes of incident investigations.

Seeking and acting on feedback from patients, the public and staff

- The service had undertaken limited active patient engagement which extended only to the mandatory Friends and Family (FFT) test.
- The provider had not undertaken formal staff appraisals.
- Although we saw minutes of governance and staff meetings, which included governance meetings with the hospital trust and commissioners, there was no structured meeting schedule in place.
- The provider had recently revised the format of its staff bulletin and we saw the July 2017 issue included incidents, complaints, compliments and patient safety alerts.
- The provider had organised a reception away day the week before our inspection to communicate to staff regarding the management changes in an informal environment.

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 How the regulation was not being met: The provider was failing to ensure that care and treatment was provided in a safe way for patients: • There was no effective system and process in place to ensure patient safety alerts were effectively shared with all staff. • There was no clearly defined system in place for the safeguarding of children and adults. • Performance targets to ensure patients were receiving care and treatment in a timely manner were not achieved. • There was no effective system to ensure clinicians were up-to-date with and following current evidence-based guidance. • There was an inadequate clinical audit programme to drive improvement in patient outcomes. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider was failing to ensure:

- Sufficient numbers of suitably qualified, competent, skilled and experienced persons were consistently deployed to meet the fundamental standards of care and treatment.
- Staff had received a formal appraisal necessary to enable them to carry out their duties.
- Staff had received training which included safeguarding children, safeguarding adults, fire safety awareness, infection prevention and control and basic life support in adherence to the provider policy.

This was in breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: • We found that systems and processes were failing to ensure accurate reconciliation of all patient x-rays. It came to our attention that you did not have accurate and full data of patients who have undertaken an x-ray. • We found systems and processes were failing to ensure an effective clinical review of all x-rays following receipt of radiologist's clinical findings to ensure missed fractures were identified. • We found that systems and processes were failing to ensure effective recall of all patients with missed fractures to ensure appropriate management was initiated. • We found that systems and processes were failing to alert you to a backlog of xray clinical reviews. It came to our attention that there were in excess of 1500 x-ray reports to be reviewed. • We found that systems and processes were failing to ensure that learning and outcomes from all categories of significant incidents were effectively shared and monitored to prevent the same happening again. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.