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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Key findings

Contents

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Mary's Urgent Care Centre (UCC) on 13 July 2017. The overall rating was inadequate and the provider was placed in special measures for a period of six months. In addition, we took enforcement action in the form of a warning notice in respect of good governance and informed the provider that they must become complaint with the law by 18 August 2017.

In response to the enforcement action taken, the provider sent us an action plan outlining improvements that had been put in place since our previous inspection. We then carried out an announced focused follow-up inspection on 22 August 2017 to check that the necessary improvements had been made in respect of the warning notice, or whether further enforcement action was required. At the inspection we found improvements had been made to prevent further enforcement action.

The comprehensive report for the July 2017 inspection and the report of the focused follow-up inspection in August 2017 can be found by selecting the 'all reports' link for St Mary's Urgent Care Centre on our website at www.cqc.org.uk.

This inspection, carried out on 27 March 2018, was an announced comprehensive inspection to review in detail the actions taken by the provider since our July and August 2017 inspections to improve the quality of care and to confirm that the provider was now meeting legal requirements.

Overall the provider is now rated as Requires Improvement.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

At this inspection we found:

- The provider had addressed the findings of our previous inspection and was able to demonstrate improvements in safeguarding, staffing, fire safety and systems and process for the sharing of learning and outcomes from significant events and patient safety alerts.
- There were systems in place to safeguard children and vulnerable adults from abuse and staff we spoke with knew how to identify and report safeguarding concerns. All staff had been trained to a level appropriate to their role.
- There was an open and transparent approach to safety and systems were in place for recording and reporting significant events. An effective process to share learning with staff had been implemented.
- Systems had been introduced to manage patient safety alerts and staff were able to give examples.

Summary of findings

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and had improved their processes.
- The service reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The provider demonstrated an understanding of the service's performance and had made considerable improvements in some of its performance targets. However, there was evidence that one target was still not being met which impacted on patients receiving care and treatment in a timely manner and had a potential impact on other services.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from patients and staff, which it acted upon.
- The provider was aware of the duty of candour and examples we reviewed showed the service complied with these requirements.
- The service told us its strategy for the next 12 months was to maintain the improvements it had made since our last inspection. However, there was no formal strategy to provide assurance of resilience to support its priorities for delivering good quality sustainable care.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Maintain oversight of the significant incident reporting process to ensure these are managed within the appropriate timeframe.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

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

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 UCC premises are owned by the hospital trust.

The 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 Local Clinical Director, supported by two lead clinicians, a Lead Nurse and a Clinical Services Manager.

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 service 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 practitioners (ENPs), emergency care practitioners (ECPs) and an associate physician (AP). The UCC provides assessment and treatment of minor illness and minor injuries for adults and children. 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 that 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 directed to separately located premises. The UCC is accessible by both an internal and external route within the hospital trust estate which takes approximately 10 to 30 minutes to walk dependent on pace, ambulatory capability or whether an internal or external route had been chosen.

Detailed findings

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

Good

Are services safe?

Our findings

At our inspection on 13 July 2017, we rated the provider as inadequate for providing safe services as the arrangements in respect of safeguarding, ensuring sufficient numbers of staff and skill mix needed to meet patients' needs, fire safety, patient safety alerts and significant events were not adequate.

At this inspection we found that the provider had made considerable improvements in all areas identified at our previous inspection. The provider is now rated as good for providing safe services.

Safety systems and processes

We found the provider had addressed the shortfalls identified at our previous inspection and had established systems and processes to minimise risks to patient safety. In particular:

- Safeguarding policies had been ratified and were accessible to all staff. All staff we spoke with could demonstrate how to access them on their desktop and there was a centrally maintained hard copy of all policies within the centre. The policies clearly outlined local safeguarding arrangements and we observed safeguarding contact details and flowcharts were also displayed in consultation rooms.
- Staff we spoke with demonstrated they knew how to identify and report concerns. They told us they received support and feedback when raising concerns.
- There was a local safeguarding lead and all staff we spoke with knew who it was. An organisation-wide strategic safeguarding lead had also been recruited in January 2018.
- All substantive staff, both clinical and non-clinical, had received up-to-date safeguarding children and vulnerable adults training appropriate to their role. For example, the safeguarding leads had been trained to safeguarding children level four, clinical staff to level three and non-clinical staff to level two. All sessional and agency staff were required to provide evidence of safeguarding training prior to them undertaking clinical sessions and we saw evidence that this had been recorded.
- The service had established links with the Clinical Commissioning Group (CCG) safeguarding lead and attended local safeguarding board meetings.
- The service had recorded eight safeguarding children referrals and 10 adult safeguarding referrals in the past 12 months. Referrals were made through local processes but also recorded on its incident reporting and risk management software. We saw that learning from safeguarding was cascaded through a monthly bulletin.
- Staff who acted as 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. Patient information regarding the availability of a chaperone service was available in several languages in the waiting area.

The provider had an effective recruitment system in place which was managed centrally. We spoke with the national head of recruitment and were able to access the recruitment database to review files for substantive, sessional and agency staff. We randomly selected four clinical and two non-clinical staff files and saw appropriate checks had been carried out at the time of recruitment. For example, interview notes, proof of identification, qualifications, references, registration with appropriate professional body, inclusion on a performer's list, medical indemnity and appropriate DBS checks.

There was an effective system to manage infection prevention and control (IPC) which included a nominated IPC lead, training for all staff relevant to their role and regular audit. The hospital trust cleaning team was responsible for cleaning the premises and we saw that appropriate standards of cleanliness and hygiene were maintained.

Staff we spoke with knew the location of the fire evacuation assembly point and told us a fire evacuation drill had been undertaken in November 2017. The provider had nominated responsible fire officers and details were displayed within the centre. Fire training had been delivered by the trust's fire officer in November 2017 and those not able to attend had access to on-line training. Training compliance for fire awareness at the time of our

Good

Are services safe?

inspection was 97%. Staff told us they received safety information from the service as part of their induction and on-going training which included health and safety and manual handling.

The premises were managed by the hospital trust's facilities management team and we saw that various risk assessments had been carried out which included Legionella (Legionella are bacteria that can contaminate water systems in buildings) and fire. We saw evidence that the fire alarm warning system and fire extinguishers were checked on a weekly basis. The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

Since our previous inspection the provider had made some senior leadership appointments which included a substantive Local Clinical Director, Clinical Services Manager and Lead Nurse. The provider had reviewed its workforce and undertaken recruitment events which had resulted in a steady increase in substantive staff. Data provided to commissioner's for February 2018 showed that permanent staff had increased to 67%. The provider told us that of the 33% of non-substantive staff usage in February, 93% of the hours filled were by a regular cohort of sessional and agency staff whom had worked regularly with the service for over six months. In addition, rota data provided to commissioner's showed that uptake in shift fill for December 2017 was 98%, January 97% and February 99%. This was an improvement on our findings when we inspected in July 2017 when shift fill had been 84%.

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 centre 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 daily and we saw evidence of a check list. We saw that staff had undertaken basic life support training.

Both clinical and non-clinical staff we spoke with understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. We saw that guidance was readily available in all consultation rooms, for example how to identify symptoms and treatment of sepsis and a traffic light system for identifying risk of serious illness. Each clinical room had dedicated equipment for the assessment of sepsis, for example, adult and paediatric pulse oximeters, blood pressure machine and thermometer. Staff told patients when to seek further help and advised patients what to do if their condition got worse.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. We reviewed random care records and these showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, special notes were available and alerts were added to the system for patients identified as vulnerable. A summary of the care provided was shared with patients' GPs.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

On the day of the inspection we found that the service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and vaccines, minimised risks. There were processes in place for checking medicines and equipment and staff kept accurate records.
- There was 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. Prior to our previous inspection there had been two

cold chain breaches (a system of storing medicine requiring refrigeration within a recommended temperature range of +2 to +8°C). At this inspection, all staff we spoke with demonstrated a good knowledge of the cold chain, including when vaccines were delivered and when to escalate if the temperatures were out of the specific ranges.

- At our previous inspection the service held a range of 'to take out' (TTO) medicines (pre-packed and pre-labelled medicines) for patients. The service no longer held TTO medicines. All patients were given a prescription or directed to pharmacy for over-the-counter (OTC) medicines.
- The service did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- The service had systems in place to ensure prescription stationery security. A recent prescription stationery audit had been undertaken to review the risk of prescriptions being unaccounted for, discarded/spoiled or stolen. The outcome of the audit was to use one centralised dedicated printer for all prescriptions generated. The provider told us this had had a positive impact on the process of controlling and monitoring prescriptions. The provider had a contingency in place for failure of the printer.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. We saw that all staff had access to the current local prescribing formulary.
- The provider had adopted Patient Group Directions (PGDs) in line with regulation to allow non-prescribers to administer medicines in the centre, for example, paracetamol. At the time of our inspection updated PGDs were with the Clinical Commissioning Group (CCG) for sign off. As an interim measure prescribers were supporting non-prescribers with prescriptions. All staff we spoke with were aware of this and we saw it had been referenced in the February 2018 bulletin.

Track record on safety

At our previous inspection, the service had not been able to demonstrate a good safety record and we had found concerns which impacted on patient safety. At this inspection the provider demonstrated improvements had been made and we found:

- Comprehensive risk assessments had been undertaken in relation to safety issues.
- Activity was monitored and reviewed. This helped the service understand risks and gave a clear, accurate and current picture.
- There were processes in place to learn from incidents and joint reviews had been carried out with partner organisations.
- There were mechanisms in place to receive and act on patient safety alerts.

Lessons learned and improvements made

We found the provider had addressed the findings of our previous inspection and now had systems and processes in place to ensure learning and outcomes from all categories of significant incidents were effectively shared and that there was monitoring of ongoing incidents and risks at both local and organisational level. In particular:

- The provider demonstrated its system for recording and acting on significant events. There was an incident policy and all categories of incident were recorded on its incident reporting and risk management software. Training on the software was part of the provider's mandatory training schedule.
- Staff we spoke with understood their duty to raise concerns and report incidents and near misses and knew how to do this. They told us they were supported when they did so and received feedback from managers which they found beneficial.
- The provider had undertaken an audit of its serious incidents by classification for 2017 to identify any trends and learning. There had been six serious incidents reported between January 2017 and December 2017. This represented 0.01% of the total patient contacts (69,906) for this period. A finding of the audit had been non-compliance against some deadlines to complete and close historical investigations. The service attributed this to the level of experience of incident management and investigation within the team and governance staff turnover. A governance co-ordinator had recently been recruited to oversee operational and clinical incidents organisation-wide and an interim

governance co-ordinator had been assigned to the centre to help address the non-compliance. We saw that serious incident reporting had been retained on the risk register. The provider told us that until it was assured that its processes were effective and it was consistently meeting its timelines for contractual reporting it would remain a risk. They told us improvement would be measured through regular audit reviews.

- We looked at and discussed two recent serious incidents in detail and saw there were adequate systems for reviewing and investigating when things went wrong and saw that lessons had been learned and action taken to improve the safety in the service. For example, the provider had undertaken a joint investigation and end-to-end review with the hospital trust which had resulted in an enhancement of the equipment available on the centre's resuscitation trolley.
- The service demonstrated it shared lessons and outcomes through monthly email bulletins from the Local Clinical Director to all substantive, sessional and agency staff. We reviewed the content of bulletins from October 2017 to February 2018 and saw several examples which included the outcome of an investigation with the trust's security team following an abusive incident towards staff. The provider had observed a noticeable increase in incidents as a result of abusive and/or violent behaviour and had arranged immediate conflict resolution training for staff and had produced multi-lingual posters which outlined the service's commitment to zero tolerance. We saw the provider had reiterated staff safety and how to raise an alarm in the monthly bulletin. Both clinical and non-clinical staff we spoke with confirmed they received bulletins and were able to give examples of recent learning. We observed that there was also a hard copy maintained in the centre for reference.
- We saw evidence that the provider had complied with the Duty of Candour (a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Since our last inspection the provider had produced a patient leaflet to guide patients and carers on the Duty of Candour requirements and process.
- The provider had commenced daily risk meetings since our previous inspection and we saw minutes of meetings where issues such as incidents, staffing and performance issues were discussed in real-time. 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. At our previous inspection the risk register had not been reviewed and updated regularly. We saw that there was ownership of the risk register and it was reviewed and updated at fortnightly quality and safety meetings attended by the service leads.
- We saw evidence that the provider shared incidents with its commissioners in its monthly quality report. The report outlined incidents captured, any identified trends and action taken. The provider also had processes in place to share information with other organisations such as the National Reporting and Learning System (NRLS) and the Care Quality Commission (CQC). Prior to our inspection the provider had submitted a notification to CQC in line with the statutory notification requirements.

The provider had put mechanisms in place to disseminate alerts to substantive, sessional and agency staff through its monthly bulletin. We saw action had been taken in response to a recent bulletin from Public Health England (PHE) regarding measles outbreaks. We saw the service had disseminated PHE's measles and post-exposure guidance to clinical staff, provided written guidance to receptionists on symptoms and conditions, the importance of patient isolation, PHE's notification requirements and displayed posters for patients, which we saw were available in several languages aligned to the patient demographic.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection on 13 July 2017, we rated the provider as inadequate for providing effective services as there was no effective system in place to ensure clinicians were up-to-date with or following current evidence-based guidance, there were gaps in induction, appraisal and training records, there was no clinical audit programme to drive improvement in patient care, there was a backlog with the process for cross-checking x-ray reports and performance targets to ensure patients were receiving care and treatment in a timely manner were not met.

At this inspection we found that considerable improvements had been made. However, the provider was still failing to achieve one of its performance targets which impacted on patients receiving care and treatment in a timely manner and had a potential impact on other services. The provider is now rated as requires improvement for providing effective services.

Effective needs assessment, care and treatment

There was an effective system in place to ensure clinicians were up-to-date with or following evidence-based guidance:

- Guidance and up-dates were communicated to all substantive, sessional and agency staff through monthly email bulletins from the Local Clinical Director. We reviewed the bulletin for February 2018 and saw that updated National Institute for Health and Care Excellence (NICE) Antibiotic Guidelines for Sore Throat had been disseminated. Clinical staff we spoke with on the day confirmed they received bulletins and were able to give examples of recent updates received.
- Qualitative and quantitative clinical performance reviews had been introduced quarterly to monitor the effectiveness and efficiency of patient care provided by each clinician. Five random clinical notes were reviewed for each clinician and an assessment was made on effectiveness by reviewing the standard of note keeping and the appropriateness of the management provided for each case, and on efficiency by looking at the average length of consultation, number of patients dealt with per hour and the overall outcomes of each case, including appropriate clinical coding. Outcomes were discussed in one-to-one reviews and formed part of the annual appraisal. There was a process in place for further review of clinicians not meeting the performance criteria.

Clinical staff we spoke with demonstrated they had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We randomly reviewed some clinical notes and saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. There was no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service used key performance indicators (KPIs) that had been agreed with its clinical commissioning group (CCG) to monitor their performance and improve outcomes for people. At our previous inspection we found that performance for the streaming (the process of allocation of patients to the most appropriate clinical pathway) of adults within 20 minutes of arrival had been below the target of 95% with achievement ranging from 39% to 82%. The provider sub-contracted the hospital trust to undertake paediatric streaming and we found that the target of 95% had been consistently achieved and ranged from 99% to 100%.

At this inspection the provider told us they had put actions in place to improve performance in this area which included improvements in daily rota fill, staff skill mix available and the provision of streaming and triage training for clinicians. We reviewed comprehensive daily and monthly performance data for the period October 2017 to February 2018 which showed there had been considerable improvement with the provider meeting the target of 95% in all but one month, which had included a period of winter pressures when there had been an increase in patient demand. Data showed that in October 96% of adults who arrived at the service were streamed within 20 minutes, in November 98%, in December 96%, in January 94% and in February 97%.

The provider continued to sub-contract paediatric streaming to the trust and we found that achievement was 100% for the period October 2017 to February 2018. The provider told us there was no plan to change this arrangement in the immediate term.

Requires improvement

Are services effective?

(for example, treatment is effective)

Other performance data reviewed showed that the provider had improved its achievement of people who arrived at the service and completed their treatment within 4 hours. Data for the period October 2017 to February 2018 showed that the service had met their target of 95% every month (October 98%, November 99%, December 97%, January 99% and February 99%).

We saw that the provider was outside its target for re-directs from the UCC to A&E. Specifically, data showed that the provider was not meeting the target of 90% on re-directs from the UCC to A&E in under two hours which could have a negative impact on patients receiving care and treatment in a timely manner and impact on A&Es performance targets. We reviewed a recent audit for the period 1 November 2017 to 31 December 2017 which showed that 55% of patients were redirected over the two-hour target. Further data for January and February 2018 showed that only 40% and 52% respectively had been redirected in less than two hours which was well below the 90% target. However, the provider was aware of this and we saw evidence that attempts were being made to address the shortfall. The provider had met with the trust and had reviewed and amended some of the streaming pathways in an attempt to improve the process. The provider told us they would re-audit in May for the period 1 March 2018 to 31 April 2018. Since the inspection the service have told us that data for April 2018 showed an improvement in the performance of redirects from the UCC to A&E.

The service was also reviewing its patient pathways and referrals to A&E with the trust after it was identified that potentially unnecessary referrals had been made to A&E which should have been dealt with in the UCC.

The provider demonstrated improvement in the systems and processes for cross-checking x-ray reports. All patients presenting to the 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 able to demonstrate from a recent audit in February 2018 that 100% of patients had been contacted within 24 hours of a missed fracture being identified. The provider told us they had engaged with the trust's radiology department to reduce the turnaround time for the reporting of x-rays from approximately seven days to just over one day. In conjunction with the trust's radiology team, training had been delivered to help clinicians improve their skills or interpreting plain x-rays. A random review of patient records showed that patients had been contacted in a timely manner and appropriate treatment commenced when a missed fracture had been identified.

At our previous inspection we found the provider could not demonstrate an effective clinical audit programme to drive improvement in patient outcomes. At this inspection we found the local clinical team had engaged with its national audit manager and agreed an audit programme for the period August 2017 to July 2018. Several two-cycle audits related to the findings of our previous inspection had been undertaken. For example, monitoring of x-ray reporting, adverse events and serious incidents, safeguarding and clinical notes reviews. The provider had also identified audits to drive patient outcomes, for example, antibiotic prescribing, diazepam prescribing and a streaming to discharge audit in conjunction with the trust.

Effective staffing

At our previous inspection we found there were gaps in induction, appraisal and training records. At this inspection we found improvements had been made and we saw evidence that:

- All staff were appropriately qualified and had the skills, knowledge and experience to carry out their roles. We saw that up-to-date records of skills, qualifications and training were maintained. Clinical staff who had not completed mandatory training were hibernated on the rota system and could not be allocated shifts until they could demonstrate compliance. This had been communicated to staff in a recent bulletin to ensure they were aware of the requirement.
- The provider had an induction programme for all newly appointed staff which included sessional and agency staff. The induction included a corporate and local overview, safeguarding, incident reporting, information governance and role-specific topics such as assessing mental capacity, medicine management, streaming guidance, identifying serious illness and red flags. The induction included access to role-specific on-line training, for example, 'Spotting the Sick Child.'

Requires improvement

Are services effective?

(for example, treatment is effective)

- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. The provider had appointed two lead clinician posts to support the role of the Local Clinical Director. The clinician leads were available for support and advice whilst clinicians were on their shifts.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop. The provider had recently delivered training on streaming and interpretation of x-rays.
- The provider provided staff with ongoing support. This included clinical supervision, one-to-one meetings and appraisals.
- Quarterly qualitative and quantitative clinical performance reviews were undertaken for all clinicians and there was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. For example, there were daily briefings with the trust's A&E team to improve patient management across A&E and the UCC.
- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, we saw pathways and guidance on referral to the Surgical Assessment Unit (SAU).
- Staff communicated promptly with patients' registered GPs so that the GP was aware of the need for further action. An electronic record of all consultations was sent to patients' own GPs. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, we saw guidance and pathways on referrals to mental health services.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service. An NHS 111 booked appointment service was scheduled to go live immediately after our inspection.

Helping patients to live healthier lives

As an Urgent Care Centre (UCC) the service did not have the continuity of care to support patients to live heathier 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 we spoke with told us they were committed to the promotion of good health and were proactive in empowering patients, and supporting them to manage their own health and maximise their independence. Staff told us where risk factors were identified these were highlighted to their normal care providers through electronic communication or, if urgent, by phone or fax. Where patients needs could not be met by the service, staff told us they redirected them to the appropriate service for their needs.

Staff told us they encouraged and assisted patients to register with a local GP and we saw patients leaflets in the waiting room which provided guidance and information on how to register with a GP.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

At our inspection on 13 July 2017, we rated the provider as requires improvement for providing caring services as they had not considered how patients with a hearing impairment would access the service, patient information was not available in languages aligned to the service demographic and privacy and confidentiality in the waiting area required improvement.

At this inspection we found that the provider had addressed and actioned all the issues raised at our previous inspection. The provider is now rated as good for providing caring services.

Kindness, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients and treated them with kindness, respect and compassion.

- At our previous inspection we observed there was a lack of physical space in the UCC. The waiting room was small and seating faced the reception cubicle which meant it was possible that conversations could be overheard by patients. At this inspection we observed that the service had reconfigured the seating in the waiting room so patients were no longer facing the reception desk. The service had replaced the previous fabric chairs with wipeable chairs and a television and patient information screen had been installed. We saw that waiting time information was on display, which had not been available at our previous inspection.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- Curtains were provided in consulting room 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 12 patient Care Quality Commission comment cards, nine of which were positive about the service experienced. Comments included very good and quick service and that they were treated with dignity and respect. Three comment cards contained negative comments which included waiting times to be seen.

At our previous inspection we found the provider was collecting patient feedback through the NHS Friends and Family Test (FFT) but this was not actively promoted. We found that only 115 surveys had been returned for a one year period (May 2016 to May 2017) of which 58% of patients said they would be extremely likely or likely to recommend the service. At this inspection we found that the provider was actively promoting the FFT after each clinical episode and within the waiting area and data showed that there had been an uptake in feedback. For example, 102 surveys had been returned for February 2018, of which 79% of patients said they would be extremely likely to likely to recommend the service. We saw that the provider was displaying the outcomes of patient feedback in a 'you said, we did' format. For example, the service provided a real-time waiting time board in response to patient feedback.

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

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- At our previous inspection we found that patient information was only available in the English language. At this inspection we found the service had reviewed its patient information literature and provided leaflets in Polish, Spanish and the Arabic language. They provider told us that these languages aligned to the majority of their non-English speaking patients. In addition, an information screen had been installed in the waiting room and was displaying information on chaperoning, safeguarding, how to make a complaint and provide feedback and fire safety in English and the identified languages.
- Interpretation services were available for patients who did not have English as a first language. Staff we spoke with knew this service was available and how to access it. We saw notices in the waiting area informing patients

Good

Are services caring?

this service was available and there was a language identification poster which assisted staff to identify the language spoken as patients were able to point to the language they spoke.

- Staff communicated with people in a way that they could understand, for example, since our last inspection the provider had installed a hearing loop. We saw that an easy read version of the patient leaflet had been designed using photo symbols. We saw evidence that the provider had recently engaged with Healthwatch (an independent national champion for people who use health and social care services). An outcome of the meeting had been for further engagement with Healthwatch members to review patient information and leaflets. This was ongoing at the time of the inspection.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. We saw evidence that 100% of staff had undertaken equality and diversity training. Feedback from CQC comments cards was that patients felt they were treated with dignity and respect.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The service complied with the Data Protection Act 1998. The service was registered with the Information Commissioner's Office (ICO). We saw that 97% of staff had undertaken information governance training.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our inspection on 13 July 2017, we rated the provider as good for providing responsive services. At this inspection we have also rated the provider as good for providing responsive services.

Responding to and meeting people's needs

- The provider engaged with commissioners to secure improvements to services where these were identified. The service understood the needs of its population and improved services in response to those needs. For example, the provider had recently engaged with and attended a meeting of the Clinical Commissioning Group (CCG) Homelessness Partnership Board to explore appropriate sign posting for people of no fixed abode attending the UCC at night and avenues of help and support available to them to guide the UCC staff.
- There was a lack of physical space at the UCC, however, reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. There was a ramp and an automatic door leading to the main entrance, accessible toilet facilities, a baby changing area and an induction hearing loop had been installed. Interpreter services were available for patients whose first language was not English. The provider had translated its patient information leaflets into several languages aligned to its patient demographic and an easy-to-read version was available. There was a wheelchair available for patients requiring assistance.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients could access the service either as a walk in-patient, via the NHS 111 service (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) or by referral from a healthcare professional, such as their own GP. 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.
- Patients were able to access care and treatment at a time to suit them. The service operated 24 hours a day, seven days a week including bank holidays.
- 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 presented to reception and 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. Patients were streamed by a UCC clinician to determine their care pathway. Paediatric streaming was sub-contracted to the hospital trust and there was a separate child-friendly waiting area. If the pathway was to be seen at the UCC then the patient would be directed to the centre. Since our inspection in July 2017 the provider had improved its information for patients on the streaming process by way of a multi-lingual leaflet and clinical streaming sheet to hand in upon arrival at the UCC. This was an improvement on our inspection in July 2017 when patient information was minimal and only available in English.
- Patients were generally seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response.
- The service had made improvements to meet its commissioners KPIs. For example, data for the streaming of adults within 20 minutes of arrival showed that the service had met the target of 95% in all but one month between October 2017 and February 2018 (October 96%; November 98%; December 96%; January 94%; February 97%).
- The service told us it monitored waiting times and made changes to manage and mitigate risk where required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

For example, the provider held daily internal risk meetings which reviewed rota fill, skill mix and streaming performance and the Clinical Services Manager met twice a day with the trust for a streaming and triage update in real-time which gave both services the opportunity to respond to any surges in demand to avoid potential breaches. Patients were advised of anticipated waiting times. At the inspection we saw the service displayed a real-time waiting time board in the waiting room.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- The provider had an effective system in place for handling complaints. The complaints policy and procedures were in line with recognised guidance and was accessible to staff.
- Patient information about how to make a complaint or raise concerns was available in the centre in English, Polish, Spanish and the Arabic language.
- All complaints were recorded on the provider's incident reporting and risk management software. For the period April 2017 to February 2018 the provider had received 79 complaints. We saw that the provider had noted in its February 2018 quality report to its commissioners that there had been an 85% reduction in complaints since August 2017 with only two received in February, the lowest number for a year. The provider had commented that the decrease in complaints about clinical treatment and waiting times could be attributed to improved rota fill and skill mix of staff available on shifts.
- We reviewed a selection of complaints and found that they were satisfactorily handled in a timely way and with openness and transparency. We saw the service learned lessons from feedback, individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the provider had produced a patient triage and streaming booklet following feedback regarding confusion around the patient pathway. We saw that the leaflet was available in four languages aligned to the patient demographic and an easy-to-read version.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. For example, the provider had engaged with the trust around patient pathways and referrals to A&E after it had been identified that potentially unnecessary referrals had been made to A&E which should have been dealt with in the UCC. The provider had noted that there had been a lack of skilled paediatric clinicians available on some shifts which had impacted on A&E by the unnecessary referrals. The provider told us that all new staff allocated shifts are required to be appropriately skilled to see adults and children.

Are services well-led?

Requires improvement

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

Our findings

At our inspection on 13 July 2017, we rated the provider as inadequate for providing well-led services as the arrangements in respect of governance oversight at both a local and organisational level was not adequate. Enforcement action was taken against the provider in the form of a warning notice.

We subsequently undertook an announced inspection on 22 August 2017 to follow-up on the requirements of the warning notice and found arrangements had improved. At this inspection we found that the provider had maintained the improvements observed at our inspection on 22 August 2017. Although the provider could demonstrate considerable service improvements since our previous inspection and told us their strategy was the maintain these improvements, we did not see a formal strategy to support this which could provide assurance of resilience and sustainability.

The provider is now rated as requires improvement for providing well-led services.

Leadership capacity and capability

At our previous inspection we found a lack of strong clinical and managerial leadership and key members of the leadership team had resigned immediately prior to our inspection which had necessitated the secondment of an interim team from within the corporate organisation. At that time the provider had been transparent about the challenges with recruitment, workforce capacity, skill mix and a high reliance on agency staff. At this inspection we found that the provider had made some senior leadership appointments which included a substantive Local Clinical Director, Clinical Services Manager and Lead Nurse. The provider demonstrated progress with recruitment and data showed an increase in substantive staff, daily rota shift fill and skill mix needed to meet patients' needs. However, it was not possible to measure the stability and sustainability of the improvements made so far over time. For example, the provider could not demonstrate a long-term strategy for the retention of staff.

The clinical and non-clinical leadership team we spoke with demonstrated they had the capacity and skills to deliver high-quality, sustainable care. They were knowledgeable about issues and priorities relating to the quality and future of the service. Since our last inspection they had actively engaged with commissioners and the trust to work collaboratively to address the issues identified. Feedback we received from both stakeholders confirmed that there had been progress in collaborative working since our last visit and the trust told us that there had been more effective communication in hours between senior service and operational leads which enabled both services to address in real-time potential impact on services.

Clinical and non-clinical staff we spoke with on the day told us there was a clear and visible management team. At our previous inspection staff told us they had not felt supported in their day-to-day role due to the lack of a consistent leadership. At this inspection staff told us there had been a positive impact on the service as a result of the new management team and they felt supported and valued. They told us they felt the improvements to organisational systems and processes and had had a positive impact on patient care and safety.

The provider had implemented a formal meeting structure at local and organisational level and with stakeholders. We saw minutes of clinical, operational and quality and safety meetings. Information was cascaded to staff through monthly bulletins and staff operational newsletters.

Vision and strategy

The service had a clear vision to deliver high quality care and promote good outcomes for patients.

- The provider had a mission statement to be the urgent healthcare provider and partners of choice for the NHS, with a range of services which would allow them to provide better clinically led, evidence-based, innovative and sustainable services for patients.
- To achieve its mission there was a clear set of values. The provider told us it developed its vision and values jointly with patients, staff and external partners.
- Staff were aware of and understood the vision and values and their role in achieving them. We saw they were displayed in the centre for patients and included in staff operational newsletters.
- The service told us its strategy for the next 12 months was to maintain the improvements it had made since our last inspection. However, there was no formal strategy to provide assurance of resilience to support its

Are services well-led?

Requires improvement

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

priorities for delivering good quality sustainable care. Since the inspection the service have told us that they are actively working on a formal strategy document for resilience and sustainability.

Culture

Since our previous inspection the service had made progress to create a culture of high-quality care.

- Staff we spoke with felt respected, supported and valued. They were proud to work for the service.
- We saw that the management team acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. In particular, staff told us that since the last inspection training and support had been given to encourage the reporting of incidents. They told us that they supported in the process and received feedback from managers which they found beneficial.
- There were processes for providing all staff with the development they required. At our previous inspection the provider did not have systems in place to facilitate formal staff appraisals. At this inspection we saw staff had received an annual appraisal and there were structures in place for mentorship, clinical supervision and one-to-one meetings for both substantive and sessional staff.
- Clinical staff we spoke with told us they felt valued members and were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. We saw evidence that the provider had addressed staff safety and its approach to zero tolerance following some incidents of abusive behaviour by patients.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff told us they felt they were treated equally.
- We observed positive relationships between staff and the management team.

Governance arrangements

At our previous inspection we found the provider had not implemented a governance framework at a local or an organisational level to ensure the delivery of good quality care and opportunities to prevent or minimise harm had been missed. At this inspection we found that the provider had implemented clear responsibilities, roles and systems of accountability to support good governance and management at both local and organisational level.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The provider demonstrated it had engaged with its commissioners and the trust to improve governance and bring about improvements to patient outcomes.
- Staff were clear on their roles and accountabilities including in respect of incident reporting, safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

Since our last inspection the provider had put processes in place for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Leaders had a good understanding of service performance against key performance indicators. Improvements had been made in some performance targets since our previous inspection to ensure patients received care and treatment in a timely manner. However, the provider was failing to meet one of its targets which potentially impacted negatively on patient care and treatment. We saw that the provider was aware of this and had put processes in place to manage these. For example, it was working collaboratively with the trust to address where performance was impacting on its service.
- Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.

Are services well-led?

Requires improvement

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

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- Performance of clinical staff could be demonstrated through audit of their consultations.
- The provider had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care. For example, daily risk meetings had been implemented to enable the provider to be more responsive to daily capacity and demand which included a twice daily meetings with the trust to address capacity issues collaboratively.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were effective arrangements in place in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The provider was actively promoting the NHS Friends and Family Test (FFT) after each clinical episode and within the waiting area. Data showed that there had been a considerable uptake in feedback. For example, at our previous inspection we found that only 115 surveys had been returned for a one year period. We saw for the month of February 2018 there had been 102 surveys returned of which 79% of patients said they would be extremely likely to likely to recommend the service. The provider had also engaged with Healthwatch (an independent national champion for people who use health and social care services).

At our previous inspection the provider did not have systems in place to facilitate formal staff appraisals. At this inspection we saw staff had received an annual appraisal and there were structures in place for mentorship, clinical supervision and one-to-one meetings for both substantive and sessional staff. Staff were able to describe to us the systems in place to give feedback, for example, the provider had also introduced a staff suggestion box since our last inspection. Clinical and operational information was cascaded to staff through bulletins and a newsletter.

We saw that the service was transparent, collaborative and open with stakeholders about performance. Monthly quality reports were produced for commissioners who told us the information captured in these had improved since our last inspection. Both the commissioners and the trust had provided feedback that there had been an improvement in engagement and communication with the UCC.

Continuous improvement and innovation

The provider had put systems and processes in place to promote learning, improvement and innovation.

- We saw that the service had actively engaged with stakeholders to focus on the findings of the previous inspection.
- The service demonstrated it worked in partnership with the trust, for example, to develop effective integrated patient pathways.
- The provider was working with stakeholders to transition towards an Urgent Treatment Centre (UTC) model.
- The service made use of internal and external reviews of incidents and complaints and learning was shared and used to make improvements.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider did not have sufficient systems and processes in place to achieve all its performance indicators which had a negative impact on services provided to patients. • The provider could not demonstrate a formal strategy to provide assurance of resilience to support its priorities for delivering good quality sustainable care. **This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**