Queens Urgent Treatment Centre

Inspection report

Rom Valley Way
Romford
RM7 0AG
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www.pelc.nhs.uk

Date of inspection visit: 20 and 21 October, and 7 and 8 November 2022
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Overall summary

This service is rated as Inadequate overall. The service had previously been inspected between 25 March and 15 April 2021, with a follow up inspection taking place between 10 November and 8 December 2021 The latter inspection rated the service as requires improvement overall and in the safe, effective and well led key questions. The caring and responsive key questions were rated as good. The service was found to be in breach of regulations 12, 17 and 18 of the Health and Social Care Act 2008, and requirement notices were served.

The full reports for previous inspections can be found by selecting the 'all reports' link for Queens Urgent Treatment Centre on our website at www.cqc.org.uk

We carried out an announced comprehensive inspection of Queens Urgent Treatment Centre on 20 and 21 October, and 7 and 8 November 2022. We found that some of the breaches of regulation from the previous inspection had been addressed, but others had not been. We also found breaches in other areas.

This inspection was part of a follow up on our previous system wide review of urgent and emergency care services across the North East London (NEL) integrated care system that was carried out in November 2021. At that time, we identified issues with flow in and through the urgent and emergency (UEC) pathway and had significant concerns regarding the impact of this on safety and quality of care. Due to ongoing concerns regarding the UEC pathway and patient safety, during November 2022 we inspected all four urgent treatment centres (UTC) provided by the Partnership of East London Cooperatives (PELC), and both emergency departments (ED) and medical care provided by Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT). Subsequent to significant concerns that were identified at these locations, the Commission found that the challenges these services faced were also complicated by wider challenges within the health and social care system. A Quality Summit with NHS England and system wide partners was convened to devise an action plan to address the concerns identified.

Following this inspection, the key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Inadequate

Are services well-led? – Inadequate

At this inspection we found:

- The service could not be assured that it was providing safe care to patients attending the service, particularly those with potentially serious conditions.
- There were insufficient procedures and processes in place to ensure learning from incidents and complaints. There were not clear systems in place for demonstrating improvements when things went wrong.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines. However, the service was not meeting the targets specified by its commissioners.
- The organisation did not have sufficient procedures in place to ensure that effective staffing was being provided.
- Staff involved and treated people with compassion, kindness, dignity and respect.

Overall summary

- Patients were not able to access care and treatment at the service in a timely way.
- Leaders did not have the capacity and skills to deliver high-quality, sustainable care.
- There were some clear responsibilities, roles and systems of accountability to support good governance and management. However, line of accountability and designated decision-making authority were unclear.
- The service did not have a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

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

- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of safe care and treatment.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good staffing.

The areas where the provider should make improvements are:

- Review compliance with infection protection and control guidance at the site.

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.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor, a specialist advisor focussing on the corporate function of the organisation, and a second CQC inspector.

Background to Queens Urgent Treatment Centre

Queens Urgent Treatment Centre (QUTC) is an urgent treatment service available to anyone living or working in Romford and the surrounding areas in the London Borough of Havering and North East London. The service provides treatment of minor injuries and illnesses, and provides a streaming service in order that patients are transferred to the right service either within the Urgent Treatment Centre or elsewhere. The streaming service is also the first point of contact for patients attending the emergency department of the hospital at which the centre is based.

The service is co-located on one level with the emergency department of Queens Hospital based at Rom Valley Way, Romford, Essex, RM7 0AG and is accessible to those with limited mobility.

The service is delivered by Partnership of East London Cooperatives (PELC) which is a not-for-profit social enterprise delivering NHS integrated urgent treatment services (including GP Out of Hours and Urgent Treatment Centres), to more than two million people across East London and West Essex.

The urgent treatment centre is a 24/7 NHS service for patients who walk-in, self-refer, or are referred by the NHS 111 service.

PELC provide doctors and streaming staff to the service. Other nurses and healthcare support workers are provided by North East London NHS Foundation Trust who subcontract nurse provision to PELC. Most of the clinical staff working at the service for PELC are either bank staff (those who are retained on a list by the provider) or agency staff.

The urgent treatment service is open 24 hours a day. The service sees approximately 5,000-6,500 patients per month

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

- Treatment of disease, disorder or injury
- Diagnostic and screening procedure

The service's website address is http://www.pelc.nhs.uk.

Inadequate

Are services safe?

We rated the service as inadequate for providing safe services because:

We carried out this announced comprehensive inspection between 20 October and 8 November 2022. We had previously carried out an announced comprehensive inspection between 10 November and 8 December 2021. At the time of the first inspection the service was not providing safe services, and we found the following:

- Significant incidents were sometimes reported in line with a clear policy and examples were given by staff of how learning was shared. However, we saw an example of an error that should have been reported as an incident but was not.
- The organisation had recorded very high levels of incidents not reviewed within the organisation's own timescales. Between May and August 2021 there were over 100 reported incidents that were overdue at the end of each month, which meant that the organisation could not be assured that key risks were being quickly resolved. This improved in September and October, but we also noted that the number of reported incidents decreased at the time that the backlog was in place.
- We noted that staff were washing their hands on site, and that handwashing facilities were available. However, the audits completed by the organisation showed that compliance with handwashing overall did not meet the standard set by the provider.

At the time of the inspection visit between 20 October and 8 November 2022, some of the issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- At the time of the inspection, the service was providing a full clinical assessment within 15 minutes of arrival less than five per cent of the time, against a target of 100%. Patients were routinely waiting for more than two hours for a clinical assessment.
- Between 10pm and 8am, the service was not measuring the time to initial clinical assessment of patients.
- The organisation continued to have high levels of overdue significant incidents. At the time of the inspection, 80 significant incidents remained overdue, similar to the level at the previous inspection. Staff that we spoke to said that they were not aware of learning being shared.
- Where patients with potentially serious symptoms were being delayed in referral to the emergency department, the issue was not being flagged as an incident on the system used to log incidents of potentially unsafe care.
- The last comprehensive workforce planning exercise had taken place five years ago, at a time when the service saw fewer patients. In the three months prior to the inspection, there has been a rota gap of at least 10% for doctors, and at least 20% for nursing staff. Staff that we spoke to told us that there was insufficient staffing at the service.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

Inadequate

Are services safe?

- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- At the previous inspection we noted that handwashing audits showed poor infection control compliance. At the time of the inspection, regular infection control audits were not taking place, but we observed that clinicians washed hands between patients.
- The premises were clinically suitable for the assessment and treatment of patients and could be expanded during peak periods of activity. Facilities and equipment were safe, and equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

Systems to assess, monitor and manage risks did not ensure patient safety.

- Staff 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. However, organisations that operate a front door for emergency departments, are required by NHS England to ensure that all patients are clinically assessed within 15 minutes of arrival at the site. The service was only measuring this target from 8am until 10pm, so it was not possible to determine if patients seen overnight were being managed safely.
- Where the time to clinical assessment was measured, in the three months prior to the inspection the service had assessed fewer than five per cent of patients in 15 minutes. In September and October 2022, more than half of patients streamed were taking more than 45 minutes, and in October 2022, 33% of patients were waiting more than 2 hours to be streamed.
- We reviewed clinical records to determine how quickly patients with high risk symptoms were being assessed. In one case from the last week, we saw a patient presenting with high level of chest pain taking over an hour to be assessed by a streamer and transferred to the emergency department. We saw two other cases of patients with chest pain taking an hour to receive a clinical assessment. Staff at both the emergency department and at Queens Urgent Treatment Centre told CQC that patients with presenting conditions that required urgent management were not being managed sufficiently quickly. The time to stream experienced by these patients could put patients with such significant presenting conditions at risk of serious harm.
- There were arrangements for planning and monitoring the number and mix of staff needed. However, we noted that the last comprehensive workforce planning exercise had taken place five years ago, at a time when the service saw fewer patients. In the three months prior to the inspection, there has been a rota gap of at least 10% for doctors, and at least 20% for nursing staff. Staff that we spoke to told us that there was insufficient staffing at the service, although clinical staff told us that they were supported by clinical leaders.
- There was an effective induction system for temporary staff tailored to their role.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Inadequate

Are services safe?

- Clinicians made appropriate referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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 controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use.
- The service carried out regular medicines audits 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. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- The service had a lead pharmacist who had carried out audits to ensure that prescribing was in line with national or local guidelines.

Track record on safety

The service had a good safety record as relates to risk assessments and management of alerts.

- There were comprehensive risk assessments in relation to safety issues.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the co-located emergency department, GP out-of-hours and NHS 111 service.

Lessons learned and improvements made

There were insufficient procedures and processes in place to ensure learning from incidents, and improvements made when things went wrong.

- There was a system for recording and acting on significant events and incidents. However, this was not consistently utilised by staff. Where patients with potentially serious symptoms were being delayed in referral to the emergency department, the issue was not being included on the system used to log incidences of potentially unsafe care.
- The organisation continued to have high levels of overdue significant incidents. At the time of the inspection, 80 significant incidents remained overdue, similar to the level at the previous inspection.
- Some staff that we spoke to said that they were not aware of mechanisms for learning being shared. Learning was shared through bulletins, but some staff that we spoke to told us that they did not have time to read these.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations, including the provider which employed the service's nursing staff and the local 111 service.

Inadequate

Are services effective?

We rated the service as inadequate for providing effective services because:

We carried out this announced comprehensive inspection between 20 October and 8 November 2022. We had previously carried out an announced comprehensive inspection between 10 November and 8 December 2021. At the time of the first inspection the service was not providing effective services, and we found the following:

- The key performance information that the organisation was required to submit to the commissioners was meeting 4-hour targets for patient throughput. The urgent treatment centre had not met the 98% target on any of the months from the last inspection. Between April and September, the reported performance for this was between 86% and 91%.
- The service had implemented a role called an assistant streamer to work at busy times to work along the queue to assure that patients with most serious presentations were prioritised. This role was non-clinical, but was not subject to a qualification such as Care Certificate which could assure the organisation that these staff were capable of this role. There was guidance in place, but it was insufficient to assure the organisation that a non-clinical staff member could be used for this purpose. A non-clinical member of staff outside of a robust assurance framework should not be undertaking this role. PELC removed this post immediately following the inspection.
- The organisation did not have a standard fit and proper persons framework to be used when recruiting Executive and Council staff outside of that used for all other staff.
- Staff and patients told us that shifts for doctors and nurses went unfulfilled, often due to last minute cancellations.
- The computer systems at the urgent treatment centre and the emergency department at the hospital were not compatible, so where patients were streamed to the emergency department, information could only be sent by data packet.

At the time of this inspection visit between 20 October and 8 November 2022, some of the issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- The service had combined the streamer and navigator functions into a single role. However, staff told us that the Pathways to support this hadn't been developed sufficiently. They provided an example that there had been changes to Majors B at the emergency department, and there were some patients (for example patients with urine retention) who now did not have a clear Pathway.
- Streaming staff told us that handovers to the emergency department had to be done in person, and could take 30-40 minutes. During this wait, the streaming pods could be empty, particularly overnight when only one streamer was working. We were told that a new system had been put in place a week prior to the inspection, but we still observed a handover taking over 20 minutes.
- We interviewed a range of GPs, streamers, nurses, managers and administrative staff at the site. Staff told us that there were insufficient staff at the site for the service to deliver its key performance objectives.
- The organisation was not meeting its four-hour target for patients to be discharged by the service as agreed with the commissioners. The four-hour target had been met for under 85% of patients in each of the past six months.
- Clinical supervision at the location was unclear outside of clinical guardian audits.
- The computer systems at the urgent treatment centre and the emergency department at the hospital were not compatible, so where patients were streamed to the emergency department, information could only be sent by data packet. This data was therefore not as easily accessible.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. However, assessment and delivery of care was not consistently in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Inadequate

Are services effective?

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Patients directed to the urgent treatment centre were streamed into urgent or routine. However, we saw instances of patients with potentially serious conditions not being seen sufficiently quickly to ensure they were safely managed.
- The service had combined the streamer and navigator functions into a single role. However, staff told us that the Pathways to support this hadn't been developed sufficiently. They provided an example that there had been changes to Majors B at the emergency department, and there were some patients (for example patients with urine retention) who now did not have a clear Pathway.
- Arrangements were in place to deal with repeat patients. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans, guidance and protocols were in place to provide the appropriate support. We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However, the service was not meeting the targets specified by the commissioners at the time of the inspection.

- The service used key performance indicators (KPIs) that had been agreed with its clinical commissioning group to monitor their performance and improve outcomes for people. The key target provided to the commissioners was the number of patients who were managed within four hours, with a target of 98%. Month on month, the four-hour target had been under 85% for each of the past six months.
- The service completed medicines audits, and specific audits to the service being offered. Prescribing audits were led by the lead pharmacist. The findings of audits were shared with staff. We saw a variety of two cycle audits where recommendations were shared through an organisational newsletter.
- The commissioning organisation for the service reported that they were satisfied with the organisation's performance.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, staff told us that shifts went unfulfilled, and supervision for clinical staff at the service was not safe.

- All staff had completed designated mandatory training. The provider had an induction programme for all newly appointed staff.
- Staff and patients told us that shifts for doctors and nurses went unfulfilled, often due to last minute cancellations. In the three months prior to the inspection, there has been a rota gap of at least 10% for doctors, and at least 20% for nursing staff. Staff told us that there were insufficient staff at the site for the service to deliver its key performance objectives.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Staff were provided with ongoing support. Managers told us that this included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. However, staff told us that due to high demand at the service, these measures were not consistently in place. They also told us that the only mechanism for oversight of clinical staff was through clinical guardian audits (audits of a percentage of cases managed by each clinician at the service), and there were limited mechanisms to review speed and throughput of work.

Inadequate

Are services effective?

- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making.

Coordinating care and treatment

Staff worked together, and worked well with some other organisations to deliver effective care and treatment. However, information and clinical management processes between the provider and the emergency department were inefficient.

- The computer systems at the urgent treatment centre and the emergency department at the hospital were not compatible, so where patients were streamed to the emergency department, information could only be sent by data packet. This data was therefore not as easily accessible.
- Handovers from streaming staff to the emergency department had to be done in person, and could take 30-40 minutes. During this wait, the streaming service could be unavailable, particularly overnight when only one streamer was working. We were told that a new system had been put in place a week prior to the inspection, but we still observed a handover taking over 20 minutes.
- 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.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary.
- 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 electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Relevant staff had been provided with training in the Mental Capacity Act.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.
- We observed both clinical and non-clinical staff treating patients with care, dignity and patience.

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):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- A hearing loop was in place at the service for those patients for whom it would be of benefit.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality as far as the layout of the premises allowed.
- 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.

Inadequate

Are services responsive to people's needs?

We rated the service as inadequate for providing responsive services because:

We carried out this announced comprehensive inspection between 20 October and 8 November 2022, and identified the following breaches of CQC regulation:

- The service had received 127 comment cards about the service in the year. Of these patient feedback forms, 53 specifically mentioned extremely long waits for patients either to be streamed, to be treated, or both.
- Delays were routine at the service, with most patients having to wait longer than targets in place for the service. We were told by staff that patients often left without being seen due to long waits, and that this impacted on the data integrity for the service. The exact times that patients were waiting were unclear, as some patients registered with an administrative member of staff on arrival, and others did not.
- At the time of the inspection, the service had a significant number of overdue complaints.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider engaged with commissioners to secure improvements to services where these were identified.
- The urgent treatment centre offered step free access and all areas were accessible to patients with reduced mobility.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service, including those who were included on local safeguarding registers.
- The premises in which the service was based was not purpose built for the services delivered. On this basis the layout was not the most effective arrangement for care to be delivered, although the patient pathway could be followed.

Timely access to the service

Patients were not able to access care and treatment from the service within an appropriate timescale for their needs.

- The service had received 127 comment cards about the service in the past year. Of these patient feedback forms, 53 specifically mentioned extremely long waits for patients either to be streamed, to be treated, or both.
- Patients could access the service either as a walk in-patient, via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment.
- Patients were able to access care and treatment.
- The service operated 24 hours a day, seven days a week.
- 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. However, we observed that patients with more severe conditions were not always prioritized or monitored.
- Delays were routine at the service, with most patients having to wait longer than targets in place for the service. We were told by staff that patients often left without being seen due to long waits, and that this impacted on the data integrity for the service. The exact times that patients were waiting were unclear, as some patients registered with an administrative member of staff on arrival, and others did not.

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. However, the service was not managing complaints in a timely manner.

Inadequate

Are services responsive to people's needs?

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The provider as a whole received approximately 30 complaints a month. However, at the time of the inspection more than 80 complaints were open awaiting investigation. The provider had put an action plan in place to address this backlog.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Inadequate

Are services well-led?

We rated the service as inadequate for providing a well led service because

We carried out this announced comprehensive inspection between 20 October and 8 November 2022. We had previously carried out an announced comprehensive inspection between 10 November and 8 December 2021. At the time of the first inspection the service was not providing well led services, and we found the following:

- The organisation had clarified its financial situation and the financial regulator were now satisfied with this. The organisation reported that it could now accommodate its financial position, but did not detail how this would be accomplished. A senior staff member that we spoke to told us that money provided by the commissioner to assist with winter pressures would be used in this regard.
- The organisation had improved its vision and values and leadership, and the organisation was now running in line with its constitution. However, we noted that the minuting of core meetings where risk was identified were not always sufficiently clear.
- Staff that we spoke to stated that the culture had improved, including the nurses at the service. However, some staff said that there had been an improvement but they were still not listened to.
- The Board Assurance Framework was basic, and did not provide sufficient oversight and assurance that the board was functioning as it should.
- The risk registers used by the organisation did not contain sufficient information about new measures to mitigate risk. Several factors had been on the risk register for a number of years.
- Patient engagement at the organisation was not well developed. There was no patient representative on the Council, and the organisation had not yet developed working relationships with its local patient groups.

At the time of the inspection visit between 20 October and 8 November 2022, some of the issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- A review of the governance procedures at the service undertaken by an external consultant in August 2022 found that organisational objectives were not clear and was not reflected in meetings. It also noted duplication of process and procedure across meetings.
- Staff that we spoke to were unaware of the strategic aims of the provider, and told us that they were disconnected from the senior management team. Systems for the planning and delivery of both addressing known areas that need development, and developing the strategic plan for the urgent care patient pathway were unclear.
- The service was not collecting sufficient performance information (for example safe time to stream, at all times), to determine if it was delivering against its core aims.
- There are longstanding items on the risk register, and we asked about the mechanisms for managing and removing risks, and the mechanisms for doing so were not clear.
- Staff reported that poor performance and instances of bullying and harassment were not managed at the service.
- Patient engagement at the organisation was not well developed. There was no patient representative on the Council, and the organisation had not yet developed working relationships with its local patient groups.
- Senior staff in key management positions at the organisation were on part time contracts of a limited number of hours. It was unclear how their time had been planned to ensure that they had sufficient capacity.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

Inadequate

Are services well-led?

- Some leaders had the experience, skills to deliver the service strategy and address risks to it. However, some leaders in the organisation either had very wide areas of responsibility or worked very limited hours. It was unclear how the time required to undertake these roles had been planned, particularly given areas of development that were needed at the location.
- Some senior staff were knowledgeable about issues and priorities relating to the quality and future of services. However, some staff (including senior managers themselves) reported that responsibilities had been allocated either to themselves or other staff, for which the relevant staff had little or no experience.
- Leaders at operational level were visible and approachable. However, staff told us that they were unclear on who some senior staff were, and did not see them at work.

Vision and strategy

The service did not have a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- Staff at all levels that we spoke to were unaware of the strategic aims of the provider, and told us that they were disconnected from the senior management team. Systems for the planning and delivery of both addressing known areas that need development, and developing the strategic plan for the urgent care patient pathway were unclear.
- The service was not collecting sufficient performance information (for example safe time to initially assess patients, at all times), to determine if it was delivering against its core aims.
- There was a vision and set of values in place at the service, but staff were not always aware of this.
- The provider monitored progress against delivery of the strategy.

Culture

The service had developed the culture of the service, but some staff reported that the service did not support or listen to them.

- Staff told us that they felt unsupported by leaders in the organisation, who had not increased support for them at a time when demand for the service had increased.
- Staff reported that poor performance and instances of bullying and harassment were not managed at the service.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints, but the service was not managing these issues within its own agreed timelines.
- 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.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Some staff received regular annual appraisals, but others reported that an increased workload had impacted on this level of support. Staff were supported to meet the requirements of professional revalidation where necessary.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were some clear responsibilities, roles and systems of accountability to support good governance and management. However, line of accountability and designated decision-making authority were unclear.

Inadequate

Are services well-led?

- A review of the governance procedures at the service undertaken by an external consultant in August 2022 found that organisational objectives were not clear and was not reflected in meetings. It also noted duplication of process and procedure across meetings.
- There were a number of committees and sub-committees which had crossed purposes, unclear decision making, and insufficient challenge and accountability from the non-Executive functions of the organisation.
- Structures, processes and systems to support operational governance and management were set out and understand, but there were insufficient measures in place to determine if the organisation was meeting its aims.
- Staff were clear on their roles and accountabilities including in respect of 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

The service did not have a clear risk mitigation strategy.

- There were longstanding items on the risk register, and the mechanisms for adding, monitoring and removing risks were not clear. For a number of weeks in August and September 2022, the patient record and management system had been offline. This was only placed on the risk register in early October, after the outage had been resolved.
- The provider had insufficient processes to clearly manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions Leaders had insufficient information available to them to ensure an understanding of service performance against the national and local key performance indicators
- 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.
- The providers had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service did not act on appropriate and accurate information.

- The service did not have sufficient operational information to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where staff had sufficient access to information.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements 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 service involved patients, staff and external partners to support high-quality sustainable services. However, the service had not engaged patients in service delivery.

- The service met regularly with other partners within the urgent and emergency care framework in the local area.
- There were staff council members in place from all levels of the organisation who could contribute to the strategic vision of the organisation.
- Staff were able to describe to us the systems in place to give feedback.
- Patient engagement at the organisation was not well developed. There was no patient representative on the Council, and the organisation had not yet developed working relationships with its local patient groups.

Inadequate

Are services well-led?

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1) At the time of the inspection the service was only measuring time to initial clinical assessment from 8am until 10pm. In the five months up until and including October 2022, fewer than 5% of patients were assesses in 15 minutes. In September and October 2022, more than half of patients streamed were taking more than 45 minutes, and in October 2022, 33% of patients were waiting more than 2 hours to be streamed. 2) There was no formal mechanism in place to monitor those patients waiting to be assessed during the time that they were waiting. 3) In three records that we reviewed we saw that patients presenting with central chest pain of high severity took more than an hour to be reviewed by a streamer in order that they might be referred to the Emergency Department in the hospital. 4) The service was not managing incidents within set timescales. 5) The organisation was not meeting its four-hour target as agreed with the commissioners, and streaming was not completed in a safe and timely manner. The four-hour target had been consistently under 85% for the past six months. 6) Where patients with severe symptoms requiring urgent referral to the Emergency Department were being delayed in referral to the emergency department the issue was not being routinely logged as an incident. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1) The service had combined the streamer and navigator functions into a single role. However, streamers told us that the Pathways to support this had gaps in where specific patients ought to be treated. 2) Streaming staff told CQC that handovers from them to the hospital's Emergency Department had to be done in person, and could take up to 40 minutes. On the day of the inspection, we spoke to a streamer who told us that a handover had taken 20 minutes. 3) A review of the governance procedures at the service undertaken by an external consultant in August 2022 found that organisational objectives were not clear and was not reflected in meetings. It also noted duplication of process and procedure. 4) The provider did not have clear processes for managing risk at the service. 5) Patient engagement at the organisation was not well developed. 6) Staff told us that that poor performance was not managed, and that the organisation is not sufficiently addressing bullying and harassment.
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 1) The organisation has provided its recent quality reports. In the last three months, there has been a rota-gap of at least 10% for doctors, and at least 20% for nursing staff. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.