Harold Wood Urgent Treatment Centre

Inspection report

Gubbins Lane
Harold Wood
Romford
RM3 0FE
Tel:
www.pelc.nhs.uk

Date of inspection visit: 10, 11, 17, 18 and 25 November 2021
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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	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Overall summary

This service is rated as Requires Improvement overall.

We carried out an announced comprehensive inspection of Harold Wood Urgent Treatment Centre on 10, 11, 17, 18 and 25 November 2021. We are mindful of the impact of COVID-19 pandemic on our regulatory function. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We found breaches relating to the safe, effective and well led key questions. Following this inspection, the key questions are rated as:

The key questions are rated as:

Are services safe? – Requires improvement

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 service had good systems to manage risk in most areas so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes. However, incidents were not being processed within their own specified timelines.
- The organisations own audits showed that best infection control practice was not being consistently followed.
- 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.
- Patients were able to access care and treatment from the service, although it was not routinely meeting the four-hour target for patient throughput.
- The leadership and governance functions at the organisation had been improved and were mostly in line with its constitution. However, some governance functions did not meet the needs of the organisation.
- Staff that we interviewed stated that the culture of the organisation had improved since the previous inspection, although some staff said that they were not listened to.

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

- Ensure that care and treatment is provided in a safe way to patients. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall summary

- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good staffing. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team also included a further CQC inspector, a GP specialist adviser, two members of the CQC medicines team, and a specialist advisor focussing on the corporate function of the organisation.

Background to Harold Wood Urgent Treatment Centre

Harold Wood Urgent Treatment Centre is an urgent treatment service available to anyone living or working in Harold Wood and the surrounding areas in 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 or elsewhere.

The service is located on one level at Gubbins Lane, Harold Wood, Romford, RM3 0FE and is accessible to those with limited mobility.

The service is delivered by Partnership of East London Cooperative (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 North-East London and West Essex.

The urgent treatment centre is open seven days per week between 8am and 10pm for patients who walk-in, self-refer, are referred by the NHS 111 service or are assisted in a chair by the ambulance service.

PELC provide doctors and streaming staff to the service. Streaming staff consist of doctors, nurses and paramedics. Other nurses are provided by North East London NHS Foundation Trust (NELFT) 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.

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

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

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

Requires Improvement

Are services safe?

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

At the time of the inspection visit between 10 and 25 November 2021, we identified several breaches of regulations. Specifically:

- We observed during the inspection 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 was still low.
- The first members of staff that were seen by patients on arrival at the service were streamers, and staff told us that long queues could develop. In the absence of a target for initial streaming following check in at reception, it was not clear how the organisation could assure itself that patients would be seen sufficiently quickly, particularly as staff told us that queues could be very long.
- Significant incidents were reported in line with a clear policy and examples were given by staff of how learning was shared. However, the organisation had recorded very high levels of overdue significant incidents in the time. Between May and August 21 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.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse, but some staff were not following infection control procedures.

- 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.
- 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.
- The organisations handwashing audits showed that some staff were not compliant with handwashing procedures.
- 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

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was a system in place for dealing with surges in demand, but staff reported that some shifts were unfulfilled at short notice.
- There was an effective induction system for temporary staff tailored to their role.

Requires Improvement

Are services safe?

- 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.
- The first members of staff that were seen by patients on arrival at the service were streamers, and staff told us that long queues could develop. In the absence of a target for initial streaming following check in at reception, it was not clear how the organisation could assure itself that patients would be seen sufficiently quickly, particularly as staff told us that queues could be long.
- Staff told patients when to seek further help. They 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. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe 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 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. 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.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department, GP out-of-hours, and NHS 111 service.

Lessons learned and improvements made

Requires Improvement

Are services safe?

The service learned and made improvements when things went wrong, but did not consistently manage incidents in a timely way.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The organisation had recorded very high levels of overdue significant incidents in the time. 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.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations, including NELFT and the local 111 service.

Requires Improvement

Are services effective?

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

We carried out this announced comprehensive inspection between 10 and 25 November 2021, and identified the following breaches of CQC regulation:

- The key performance information that the organisation was required to submit to the commissioners was meeting 4-hour targets for patient throughput. The UTC 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 87% and 94%.
- 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 rota called for two nurses and one GP worked at a time this could lead to gaps in coverage. Managers told us that such gaps could be covered by on call doctors for the out of hours service (also run by PELC).

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- 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. Routine patients could go back to the waiting room and wait for up to four hours. Patients who were assessed as urgent were seen more quickly. However, there was no monitoring mechanism to determine the time taken for a patient to see a navigator/streamer.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Streamers were able to assess patients in a designated consulting room.
- 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%. The UTC 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 87% and 94%
- 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.

- All staff had completed designated mandatory training. The provider had an induction programme for all newly appointed staff.
- 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 rota establishment called for two nurses and one GP to work during opening hours. Any staff absences could therefore lead to gaps in coverage. Managers told us that such gaps could be covered by on call doctors for the out of hours service (also run by PELC).
- 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.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. Managers reported that this had been more difficult during the COVID 19 pandemic, but they still met with staff either face to face or via multimedia meeting as often as was practicable. 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 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.
- 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.

Requires Improvement

Are services effective?

- 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.

- The streaming service at the site had been moved to a private room to allow for better patient privacy.
- 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.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

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 understood the needs of its population and tailored services in response to those needs. 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. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.

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 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 from 8am until 10pm, seven days a week.

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.

- 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 organisation received between seven and ten complaints per month. We reviewed ten complaints from across a series of PELC locations and found that they were satisfactorily handled in a timely way. Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. Learning from complaints was shared through the monthly 'safety matters' bulletin sent to the whole organisation.
- 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.

Requires Improvement

Are services well-led?

We rated the service as requires improvement for leadership.

We carried out this announced comprehensive inspection between 10 and 25 November 2021, and identified the following breaches of CQC regulation:

- 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. This would not be appropriate.
- 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 NELFT 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 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.

Leadership capacity and capability

Leaders had the capacity and skills to deliver care. However, at the time of the inspection, the organisation did not have a financial plan detailing how high-quality and sustainable care would be delivered in the future.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Staff told us that leaders were more visible and approachable than they had been previously. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- 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. This would not be appropriate.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.

Requires Improvement

Are services well-led?

- 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 minuted.
- Staff who we spoke to said that there had been a recent improvement in the vision and values of the organisation, and they welcomed the organisations move to a locally led operational structure.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- 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 listen to them.

- Staff that we spoke to stated that the culture had recently improved, including the nurses at the service who were employed through a subcontracted organisation. However, some staff said that there had been an improvement but they were still not listened to.
- Staff told us that following recent changes, they felt more respected, supported and valued than they had previously.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. The organisation had implemented a new bullying and harassment protocol, including a staff "guardian" following previous concerns raised by staff in this area. Staff told us that they welcomed this change, and felt confident in raising issues of bullying and harassment.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. 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, the board assurance framework did not provide adequate oversight of the organisation.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- The Board Assurance Framework did not provide sufficient oversight and assurance that the board was functioning as it should.
- 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

There were some clear and effective processes for managing risks, issues and performance. However, it was unclear from the risk register at the organisation how risk was being mitigated.

Requires Improvement

Are services well-led?

- The risk register used by the organisation did not contain sufficient information about new measures to mitigate risk in order to enable dynamic risk management. Several factors had been on the risk register for a number of years.
- The provider had processes to 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 oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- 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.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The service submitted data or notifications to external organisations as required.
- There were 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.

- A range of staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. 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. However, the organisation had recently contacted patient groups with a view to addressing this.

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. 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • 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 was still low. • The first members of staff that were seen by patients on arrival at the service were streamers, and staff told us that long queues could develop. In the absence of a target for initial streaming following check in at reception, it was not clear how the organisation could assure itself that patients would be seen sufficiently quickly, particularly as staff told us that queues could be very long. • Significant incidents were reported in line with a clear policy and examples were given by staff of how learning was shared. However, the organisation had recorded very high levels of overdue significant incidents in the time. Between May and August 21 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. • The key performance information that the organisation was required to submit to the commissioners was meeting 4-hour targets for patient throughput. The UTC 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 89% and 95%. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • 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. This would not be appropriate. • 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 NELFT 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 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 to enable dynamic risk management. 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. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The organisation did not have a standard fit and proper persons framework for onboarding executive and Council staff outside of that used for all other staff.

This section is primarily information for the provider

Requirement notices

- Staff and patients told us that shifts for doctors and nurses went unfulfilled, often due to last minute cancellations. The rota called for two nurses and one GP worked at a time this could lead to gaps in coverage. Managers told us that such gaps could be covered by on call doctors for the out of hours service (also run by PELC).

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