

VERITA

IMPROVEMENT THROUGH INVESTIGATION

An independent review of Ealing Urgent Care Centre run by Care UK

A report for
Ealing Clinical Commissioning Group

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1. Introduction

1.1 Hardcash Productions wrote to the chief executive of Care UK Ltd on 22 June 2015 alerting him to the contents of an Exposure programme due to be broadcast on ITV the following month. The letter set out a number of allegations about poor practice, sub-standard care and misreporting at Urgent Care Centre at Ealing Hospital (the UCC) run by Care UK.

1.2 Ealing Clinical Commissioning Group (the CCG), who commission the services at the UCC, were informed by Care UK on 24 June 2015. Both Care UK and the CCG recorded the programme as a serious incident and the CCG informed the CQC. The CCG also conducted a clinical site visit to the UCC and a desktop review of quality information to identify any immediate risks to patient safety. They produced the site visit report on 6 July and the desktop review report on 7 July. NHS England (London) produced an initial clinical assurance review report on 17 July. NHS England (London) reviewed and were assured by the findings of the CCG reports. Both the CCG and NHS England reports found that the UCC was safe but some improvements could be made and that an independent review of the UCC should be commissioned.

1.3 The programme entitled “*NHS Out Of Hours Undercover*” was broadcast on 22 July and used covert footage obtained by an undercover reporter posing as a work experience student at the UCC.

1.4 Ealing CCG commissioned Verita to carry out the independent review of the UCC on 10 August 2015. Verita has wide experience in undertaking reviews, primarily in services facing a range of difficulties, and has recently completed a number of investigations into reporting and practice in emergency departments in NHS trusts.

1.5 Jess Heinemann and Stephanie Bown of Verita carried out this investigation. We were assisted by clinical advisers - Mark Spencer and Amanda Rumley-Bass. Barry Morris, Verita partner, peer reviewed the report. Team biographies are shown in Appendix A.

2. Terms of reference

2.1 The overall purpose of the independent review was to identify clinical risks/concerns with patient care in the provision of services provided by Care UK in Ealing Urgent Care Centre (UCC).

2.2 Ealing CCG produced terms of reference for the investigation (appendix B). We grouped the terms of reference drafted by Ealing CCG into four key areas.

- Assess the appropriateness of the care provided within Ealing UCC - by investigating the specific allegations raised in the ITV exposure programme of 22 July.
- Consider the way in which Ealing CCG commissions Care UK to run the UCC at Ealing Hospital.
- Relationship between Ealing UCC and Ealing Hospital.
- Internal Care UK processes and governance.

2.3 Ealing CCG confirmed that these accurately captured the terms of reference.

2.4 In order to ensure timely analysis of the concerns raised and to assure the public that the concerns were being thoroughly investigated it was agreed with the CCG that the priority was to investigate the allegations made in the programme as they relate to patient care. We therefore split the work into two phases.

2.5 Phase 1 covered key areas one, two and three relating to the appropriateness of care in the UCC, the way in which it is commissioned and relationship between Ealing UCC and Ealing hospital. Phase 2 reviewed internal Care UK processes and governance.

2.6 The NHS England clinical assurance review report produced on 17 July set out expected areas of focus for our independent review. The CCG confirmed that we should respond to these recommendations. We have set out our actions completed in response to these recommendations at Appendix C.

3. Executive summary and recommendations

3.1 Ealing CCG commissioned Verita to conduct an independent review in response to allegations in an ITV Exposure programme broadcast in July 2015 about poor practice, sub-standard care and misreporting at the Urgent Care Centre at Ealing Hospital (the UCC) run by Care UK.

3.2 The terms of reference for this review were wide, encompassing an assessment of processes and systems at the UCC, at the CCG and wider Care UK processes. We considered a great deal of evidence in preparing our report, including in excess of 750 documents, 37 interview transcripts and one year's worth of UCC data.

3.3 This executive summary sets out our assessment of each allegation and a summary of the major issues in relation to commissioning, Care UK processes, the UCC's relationship and interaction with the ED and the estates at the UCC.

3.4 The evidence and reasoning for our findings is set out in the body of the main report, not in this executive summary.

3.5 During the course of the investigation we did not identify any issues relating to patient safety or any other urgent matter that needed to be escalated immediately to the CCG.

3.6 The information in this report was accurate at the time drafting was substantially completed in December 2015. Any changes or actions that have taken place since then are not necessarily reflected in the report.

The allegations

GPs who work at the UCC are not fully trained for the job (do not know how to read x-rays or how to manage fractures)

3.7 Not all GPs have all the necessary skills to perform all their duties, including interpretation of x-rays, when they start to work at the UCC. The induction, supervision, management and training at the UCC (such as the red dot course for the interpretation of x-rays), are thorough and the UCC supports new GPs to improve their skills so that they can treat the range of patients at the UCC. However, the documentation that supports these processes is not adequate. We therefore partially support the allegation and make the following recommendations.

Recommendations

R1 The UCC general manager should ensure within the next three months that all UCC GPs, including self-employed medical practitioners (SEMP), are fully compliant with statutory and mandatory service requirements.

R2 The UCC lead GPs should ask within the next month for evidence of up-to-date annual appraisals (as required by the GMC for revalidation) for all GPs working in the UCC and keep a record of that documentation on each personnel file.

R3 The UCC lead audit GP should audit one per cent of all patient consultations for all GPs notes every three months in accordance with national guidelines.

R4 UCC managers should require all practitioners who interpret x-rays in the UCC to attend the Red Dot course, or equivalent, within the next two months if they have not already done so.

R5 UCC managers should assure themselves within the next two months that the frequency and sample size of x-ray audits is sufficient so they are assured that all practitioners who interpret x-rays are competent to do so.

The national four-hour target is not being accurately reported at the UCC

3.8 We examined whether patient's time of arrival, time of departure and breaches were being reported accurately. At the time of the allegation the time of arrival was not being reported accurately, though the introduction of a new navigation and registration system in October 2015 should remedy this. The time of departure was not being accurately reported in all cases: some patients were discharged while waiting for medication or for confirmation of follow-up care. The UCC do not report a breach when a patient breaches in the emergency department (ED) who has also been treated in the UCC. National policy provides that this is permissible as long as there is a local agreement in place so that under reporting or double reporting does not occur, but such an agreement was not in place. Despite the fact that there was no deliberate attempt to mis-report breaches, the national four-hour target is not being accurately reported at the UCC and therefore we support the allegation.

Recommendations

R6 The CCG should clarify the guidance from NHS England relating to the point at which a patient's waiting time ends and agree the process with the UCC within the next two months.

R7 The CCG should agree reporting requirements of the four-hour waiting time target with the UCC and ensure that reporting is in line with national guidelines within the next two months.

R8 The CCG should confirm that when reporting the combined ED and UCC breaches the trust use UCC data that does not include any exceptions to the four-hour target within the next month.

Contractual Key Performance Indicators are being manipulated at the UCC

3.9 We do not support this allegation. We only examined whether the clinical assessment Key Performance Indicators (KPIs) were being manipulated because these were the subject of the ITV Exposure programme. In January 2015 the UCC changed the point at which they recorded the clinical assessment KPI from after their follow-up triage to after their quick navigation assessment. The triage process itself did not change - only the point at which the KPI was time-stamped. This change was a result of discussions with the CCG, who had researched standard practice across North West London.

The system for assessing patients on arrival at Ealing UCC is inadequate

3.10 We partially support this allegation. We found evidence that the ability and skill of those navigating and triaging new arrivals at the UCC was variable and that some patients were inappropriately navigated to the ED and not assigned the correct priority for follow-up triage and treatment. Some elements of the assessment process need to be improved:

- there is no standardised triage system and no protocols for assessing and treating specific conditions;
- there are no set competencies or training for navigators and assessors and their work is not audited (with the exception of paediatric observation audits); and
- navigators do not produce a full written record of all navigation discussions.

Recommendations

R9 The UCC should record all navigation discussions and decisions. The record should be given to the emergency department for patients transferred there and retained for patients navigated elsewhere. The UCC should regularly report numbers of patients navigated away from the UCC to the CCG.

R10 The CCG should ensure that as part of the new UCC contract UCC managers:

- develop detailed navigation and triage guidance and clear protocols for assessing specific conditions and symptoms based on national guidance and best practice;
- ensure that staff undergo training to ensure they understand the guidance; and
- regularly audit to ensure that the guidance is complied with.

Patient's privacy and dignity are compromised when being assessed at the UCC reception

3.11 We support the allegation: information discussed with the navigator at reception is sometimes sensitive and a patient's privacy and dignity are compromised. However we recognise that this is not an unusual situation for reception facilities in UCC and ED settings.

There are general failings in nursing and inappropriate waiting times for patients with potentially serious conditions (due to inadequate assessment)

3.12 We partially support the allegation. The line management of nurses including appraisal, audit, monitoring competencies and training is not in line with local or national policy. The UCC cannot show that nurses have the necessary competencies to carry out their work. We found that patients sometimes waited too long in the UCC. The UCC does not have a policy of performing repeat observations of patients whose observations were found at triage to be abnormal. Such a policy would provide greater reassurance that ill patients do not deteriorate in the waiting room.

Recommendations

R11 The UCC general manager should ensure within the next month that the lead nurse's non-clinical time is protected to enable him to carry out clinical leadership responsibilities.

R12 The UCC lead nurse should audit the documentation of one per cent of all patient consultations for all emergency nurse practitioners every three months. These audits should start within the next two months.

R13 The UCC lead nurse should regularly review and monitor nurse and HCA competencies to ensure they are adequately skilled to work at the UCC and keep accurate records of these reviews and competencies. This should start in the next month.

R14 UCC managers should develop a policy for performing repeat observations for patients whose observations were found to be abnormal at triage. This should start in the next month.

R15 The UCC and CCG should consider whether a quick clinical assessment at reception followed by a 'see and treat' model would work at the UCC.

Ealing UCC is seriously understaffed and staffing levels put patients at risk during busy periods

3.13 We partially support the allegation. The UCC was often understaffed and in some months the issue was escalated to managers almost daily but we found no evidence that patient safety was compromised because of a staffing problem during the day (as opposed to at night - see 3.16 below).

3.14 In 2013 Care UK asked the CCG for more funding to run the UCC because they were operating at a loss. Care UK admitted that the loss was as a result of their misjudging how long it would take to see each patient and underestimating GP salaries. The CCG did not give Care UK more money to run the contract and so Care UK asked to terminate the contract. The CCG would not allow Care UK to terminate the contract. The CCG should have sought assurances at this time that the fact that the contract was operating at a loss was not adversely affecting staffing levels and care at the UCC.

3.15 The CCG have agreed to provide extra funding to the UCC for winter 2015/16.

3.16 The process of navigation and monitoring of the waiting room at night and the level of staffing posed a clinical risk until Care UK appointed another emergency nurse practitioner to work at night in September 2015.

Recommendations

R16 The CCG should ensure that the new contract sets out predicted numbers of attendances based on data from the past contract and that a suitable staffing model is agreed.

R17 The CCG and Care UK should ensure that the addition of a staff member at night is adequate to safeguard patients.

There is a shortage of medicines at the UCC

3.17 We support the allegation but did not find that this had adversely affected patient care. Medicine stocks at the UCC were sometimes low at the time of the Hardcash programme. However, we heard no evidence from clinical staff that they could not give patients the medication they required as a result of this shortage because the UCC could acquire medications in other ways and doctors could issue prescriptions. Once the allegations became known, Care UK took steps to ensure that medications did not run out, including reiterating guidance to the UCC that stock could be ordered daily (with no minimum order) and that minimum stock levels should be adhered to while maximums were not specified.

3.18 Patients who do not require medication immediately could be issued with prescriptions in normal office hours. Medication can continue to be supplied directly to patients out of hours but patients should pay for their prescriptions unless they are exempt.

Recommendations

R18 The CCG should review the UCC contract wording about prescribing and supply of medication to align it with their strategic objectives of reducing inappropriate UCC attendances. Patients should pay for their prescriptions and medications unless they are exempt.

R19 UCC managers should regularly check stock levels of medication against quantities supplied to patients and investigate any shortfalls or discrepancies. This should start within the next six months.

A vulnerable patient was treated inappropriately

3.19 We did not see the footage of the incident that formed the basis of the allegation and so make no judgement about whether the clinician's manner towards the patient was sufficiently respectful. In response to the incident, Care UK have developed guidance for the UCC with the adult and child safeguarding leads at the CCG about the appropriate management of vulnerable patients who may attend frequently. The lead psychiatric consultant at Ealing hospital is developing guidance for the UCC about the appropriate management of frequent re-attenders.

Care UK did not ask for the reporters references, background checks or ID and she had unsupervised access to the whole UCC including the medicine cupboard

3.20 We partially support the allegation. Care UK did not check the reporter's references or conduct background checks because it was not their policy for work experience students at the time. This has since changed. The reporter was at times unsupervised with patients but she did not have unsupervised access to the medicine store.

Care UK has fallen short of standards expected of a provider of out of hours (OOH) services to the NHS and there is an existing risk to patient safety

3.21 Our clinical advisers raised one patient safety issue related to the current system of patients with asthma being nebulised in the corridor without supervision. UCC clinicians could not monitor changes in a patient's symptoms, leaving them open to the risk that the patient might deteriorate, while also compromising privacy and dignity. The lead GP told us that the clinician initiating nebulisation retains responsibility for monitoring the patient's condition, and that it was recognised that limitations in the physical space in the UCC did impact on privacy and dignity in this situation.

3.22 We do not support the allegation that there is an existing risk to patient safety.

Recommendation

R20 The CCG should consider whether to require, as part of the new contract, that any patients being nebulised in the UCC are treated with direct supervision in a separate treatment room.

Commissioning arrangements

3.23 It is not clear how the CCG assures itself about the quality and safety of the UCC service. The quality and safety section of the integrated quality and performance report (which is considered by the CCG finance and performance committee and the quality and safety committee) includes exception reports for acute, mental health and community providers for quality metrics but these do not include the UCC.

3.24 The CCG quality and safety committee relies on receiving up-to-date information on quality and safety from the contract review meetings. However, the CCG has relied too heavily on key performance indicators for monitoring the UCC contract, with inadequate discussion at UCC contract review meetings about quality. This is compounded by limited

CCG clinician or quality team presence at these meetings and no one to interpret and act on specific quality and clinical issues. This has been rectified since July 2015.

3.25 The CCG failed to recognise deficiencies in a number of UCC audits. Audits are briefly discussed at contract review meetings but no CCG clinician attended who could critically assess the methodology of audits, the results and the schedule and types of audits being submitted. The audits are not considered by the CCG in any other forum outside the contract review meetings. This is a gap in the CCG assurance processes.

Recommendations

R21 The CCG should amend the integrated performance and quality report within the next two months so that it includes UCC quality and safety information.

R22 The CCG should develop a process within the next two months for having an input into and critically assessing the UCC audit schedule and for monitoring audit quality and outcomes via their quality team.

Care UK processes

Governance processes including board assurance processes for quality and safety

3.26 Accountability for governance in Care UK from services up to the healthcare governance, risk and compliance committee is clear and the quality and safety of services is discussed in a number of forums at many levels in the organisation.

3.27 Care UK directors acknowledged that too much focus might have been put on exceptions when managing services and that this needs to be combined with softer information.

3.28 The governance manager has had a positive impact on governance at the UCC, including encouraging all incidents and complaints to be recorded on Datix¹ and strengthening local governance meetings. However, some UCC audits have been inadequate.

Recommendation

R23 The Care UK Clinical Audit and Effectiveness Group (CAG) should consider reviewing the types, methodology and quality of audits that take place in the UCC to ensure they provide an appropriate level of assurance regarding the quality of care provided.

Incidents

3.29 Discussions about serious incidents and near misses appear from the minutes of the clinical governance meetings to be more robust since the current governance manager started to attend these in April 2015. Care UK have recently introduced a governance support staff member who will keep a log of serious incident (SI) actions including evidence from services that actions have been implemented. Care UK and the CCG discuss SIs at contract review meetings but the CCG does not follow up on whether recommendations are implemented and so is not assured that learning is embedded.

3.30 We believe that misclassification of incidents at the UCC may have led to underreporting of SIs in the past.

3.31 Incidents that do not meet the criteria for reporting onto strategic executive information system (STEIS) - such as near misses - are not discussed at contract review meetings nor included in UCC reporting to the CCG. The CCG is therefore not aware of the full range of incidents occurring at the UCC. We make recommendations that will help the

¹ Patient safety and risk management software for healthcare incident reporting and adverse events

UCC remedy this. CCG quality team representation at future contract review meetings will be beneficial when discussing the full range of incidents the UCC reports.

3.32 In response to our draft report, in February 2016 Care UK told us about the policies and processes now in place for when a potentially serious incident has occurred.

Recommendations

R24 The UCC should conduct within the next two months an audit of all incidents over the past two years to determine whether any were incorrectly reported and classified. The UCC and CCG should decide whether any such incidents require further investigation.

R25 The CCG should seek assurance that the UCC process of classifying and reporting incidents is robust and in line with best practice.

R26 The UCC should report to the CCG all untoward incidents (including near misses and serious incidents), action plans and evidence of implementation. These should be discussed at contract review meetings with immediate effect.

Learning from complaints, serious incidents and patient experience data

3.33 The UCC communicates learning from incidents and complaints effectively through a variety of methods and has made recent improvements in dissemination of learning from patient experience feedback.

3.34 Learning from SIs is disseminated throughout Care UK via the Reflect newsletter and via regional medical directors to their services.

3.35 Although patient survey statistics are shared across Care UK the learning from statistics is not extracted and disseminated.

3.36 Care UK have started to use their shared learning tool to disseminate learning from SIs and believe this tool could be used throughout the organisation for any incident, complaint or claim that has lessons that could be applied to other services.

Safeguarding

3.37 Both Care UK and the CCG have increased support to the UCC to improve safeguarding since the programme. Improvements include: increasing UCC safeguarding lead capacity; moving from a paper to electronic system for identifying child protection issues; using Datix to record all safeguarding referrals and incidents; and improving compliance with mandatory training requirements. There were some outstanding issues set out in October and November UCC safeguarding audits associated with safeguarding systems and processes. These are automatically re-audited as part of the Care UK routine audit cycle.

Recommendation

R27 The UCC should deal with any outstanding issues related to safeguarding systems and processes as a matter of priority.

Links with 111 and GP practices

3.38 The system for transferring patient information from the UCC to GP practices has recently changed from using faxes to direct electronic transfer. The old system was outdated and risky and so this change is a positive step by Care UK. Care UK told us that the option had been available for some time but required agreement from individual GP practices which Care UK had pursued. The CCGs plan for interoperability between the UCC computer system and GP practices and NHS 111 should reduce duplication of processes and avoid patients unnecessarily repeating information, thereby improving flow through the UCC.

Staff raising concerns

3.39 Staff we spoke to said they felt able to raise concerns through their managers and thought Care UK was an open and transparent environment in which staff were encouraged to raise any concerns. Care UK has multiple routes for staff to raise concerns if they feel unable to use the normal channels, including both a formal whistleblowing route and an anonymous message system. Care UK managers told us that staff use these routes.

Relationship with the ED

3.40 Both the ED and UCC acknowledge that their relationship has been challenging for years. The CCG appears to have had limited involvement in this difficult relationship, yet it commissions both services and is therefore in a position to exert influence. Establishing patterns of cross-cover and working across both departments could improve relationships, understanding of the challenges and working together to implement agreed solutions.

3.41 UCC/ED meetings stopped in early 2015 and although a meeting was held in September 2015 no meetings have been organised since, no minutes circulated or follow-up actions taken. Re-establishing regular effective meetings will be crucial to improving working relationships. Clear terms of reference for the meetings, a strong chair and a defined remit will be necessary to bring about change and support joint working. We would expect meetings to be held monthly, minuted with specific action plans and covering key topics such as: patient flows, handover issues, capacity and demand, shared audits, shared clinical guidelines, significant events and serious untoward incidents and complaints.

3.42 A serious incident occurred in August 2013 in which a baby died after attending the UCC and then the ED. The trust produced a serious incident report that recommended that the ED and UCC collaborate to develop guidance and expected practice standards for use when newborn babies are admitted to either the paediatric triage area or the UCC. It is a source of concern that one of the recommendations of that SI panel report has not been

implemented. This indicates poor governance and suggests poor collaboration and communication between departments.

3.43 Navigation and transfer of patients from the UCC to the ED has caused friction between the two departments. The ED complains that some patients are inappropriately transferred and that patients who need to be treated in the ED are transferred late. The UCC is required to transfer patients to specialties via the ED, adding delays, duplicating effort and creating more traffic in the ED.

3.44 We think that there is scope for improvement in communication between the UCC and ED. The inability to transfer information electronically between the UCC and ED means that information-gathering has to be duplicated, patients have to repeat their history and transfer of care and information can be fragmented. Any barriers to transferring information or sharing access to computer systems and receptionists screens attributed to information governance could be overcome in the interests of good patient-centred care.

Recommendations

R28 The CCG should ensure that terms of reference are agreed for joint ED/UCC governance meetings and that the meetings are minuted and take place monthly. Someone senior from the CCG should attend at the outset to facilitate meetings.

R29 The CCG should ensure within two months that the UCC and ED collaborate to develop guidance and expected practice standards for use when newborn babies are admitted to either the paediatric triage area or the UCC.

R30 The CCG should work with Ealing Hospital and the UCC to explore whether it is possible to streamline the pathway for referral of patients from the UCC to specialist services.

R31 The CCG should consider stipulating in the new contract that patients who need to transfer from the UCC to the ED (not those being transferred to specialty) are transferred

within one hour.

R32 The CCG should ensure that when the new UCC contract is awarded, the UCC and ED establish processes to enable patient data to be transferred between their IT systems and consider developing a shared-screen system at reception.

R33 The CCG should consider, when the new UCC contract is awarded, requiring the UCC and ED to:

- set up joint educational/continuing professional development /audit sessions for ED and UCC staff to foster closer working relations and mutual understanding of competing departmental pressures; and
- rotate staff in order to transfer skills, knowledge and understanding between the departments. Staff must be supported by appropriate training, induction and supervision.

Estates issues

3.45 The UCC waiting area is too small for the number of patients who attend, the waiting room for children is not sufficiently separated from the main waiting area and the present layout does not meet the privacy requirements of vulnerable adults. Information about waiting times is not well displayed and not kept up to date.

Recommendation

R34 The CCG should consider ways to improve privacy at the front desk and for children and vulnerable adults in the waiting room in line with national good practice.

4. Approach and structure

4.1 The investigation consisted of observations at the UCC, individual interviews, an analysis of UCC data and an examination of all available relevant documentation. A list of the documents reviewed appears at Appendix D.

4.2 The clinical advisers were chosen for their expertise and knowledge in the area of urgent care.

4.3 First, we sent a selection of pertinent documents to the clinical advisers as background reading to the review. We then held a short preliminary meeting with them in which we discussed initial thoughts and the structure of observations we would undertake at the UCC.

4.4 We (the investigation team and clinical advisers) then visited the UCC where we followed the patient journey from registration to discharge or transfer and spoke to staff. We then held another meeting when we discussed emerging findings and areas of questioning for individual interviews.

4.5 We compiled a list of the job titles whose holders we wished to speak to as part of phase 1 of the review. The CCG, Care UK and London North West Healthcare NHS Trust (the trust) arranged the interviews.

4.6 Care UK, on our behalf, invited all UCC staff to attend a drop-in session with us at the UCC, offering them the opportunity to give us confidential comments.

4.7 We also met with the parents of a child who died in 2013 after being cared for at both the UCC and Ealing Hospital.

4.8 We presented interim findings to the CCG at the close of phase 1 of the review which the CCG shared verbally with Care UK.

4.9 In phase 2 we requested further documents and conducted further interviews with named individuals identified in the course of phase 1 of the work.

4.10 We met with the undercover reporter and producer/director of the “*NHS Out Of Hours Undercover*” programme.

4.11 We conducted 37 interviews with CCG, Care UK and trust staff including governing body members, directors, managers, nurses, doctors and administrative staff. Interviews were voluntary and held in private. A list of interviewees appears at Appendix E.

4.12 We wrote to all interviewees explaining the purpose of our work and provided them with the terms of reference and written guidance about the interview process. We made clear, among other things, that the information interviewees provided might be used in the final report and that people might be identifiable, either by job title or name (depending on the seniority of their post). Interviewees were offered the opportunity to be accompanied by a representative of a professional body or trade union, or by a colleague or a friend. With interviewee consent, interviews were recorded and transcribed and interviewees were offered the opportunity to confirm the accuracy of interview transcripts or to amend them.

4.13 We refer to individuals by job title in the body of the report. A list of interviewees and their job titles is included at Appendix E.

4.14 We analysed data from Adastra, the electronic patient record system used in the urgent care centre, for the period July 2014 to July 2015.

4.15 Our clinical advisers reviewed our draft report and provided us with written comments that we took into account when producing our final draft report.

4.16 Ealing CCG is the commissioner of this review however we have made recommendations to both the CCG and Care UK with a view to ensuring that lessons learnt from this investigation are disseminated across current and future urgent care services.

4.17 We started our investigation on 10 August 2015 and submitted a draft report to Ealing CCG and Care UK to be checked for factual accuracy on 18 December 2015. We considered all comments and feedback received from Ealing CCG and Care UK, and made drafting changes where appropriate. A final draft report was submitted to Ealing CCG for legal review on 4 March 2016.

4.18 During the course of the investigation we did not identify any issues relating to patient safety or any other urgent matter that needed to be escalated immediately to the CCG.

4.19 The information in this report was accurate at the time of drafting (December 2015). Any changes or actions that have taken place since then are not necessarily reflected in the report.

Structure of this report

4.20 Section 5 sets out the background and context to the review including a description of the patient pathway through the UCC.

4.21 In section 6 we review evidence about the allegations made in the ITV Exposure programme.

4.22 In section 7 we review the commissioning arrangements including CCG assurance and monitoring processes and information sharing.

4.23 Section 8 examines Care UK processes, governance and board assurance.

4.24 In section 9 we review the relationship between the UCC and Ealing Hospital emergency department.

4.25 In section 10 we consider issues related to layout and capacity of the urgent care centre.

4.26 The terms of reference for the review are wide - encompassing structures, systems and processes at the CCG, the UCC and throughout Care UK. As such some issues are relevant to and feature in a number of different sections. For example, we discuss serious incidents in the UCC in section 6 where they relate to the allegations, section 7 in terms of commissioning responsibilities and in section 8 how they are investigated and reported on within wider Care UK organisation. Cross-references are provided throughout.

4.27 Our findings from interviews and documents are set out in ordinary text. Summaries of our key analyses and findings appear in ***bold italics***. Quotations - which are in italics - are drawn directly either from interview transcripts or reports/policies.

5. Background and context

5.1 This section sets out both the relevant background factual information and the context within which the review took place.

Background information

5.2 The Ealing urgent care centre (UCC) is co-located with the Ealing Hospital emergency department (ED). Ealing hospital is part of London North West NHS Healthcare Trust (LNWHT, the trust). UCC staff direct patients presenting for urgent and emergency care at Ealing Hospital either to the UCC or to the ED. This is known as ‘navigation’.

5.3 Ealing Primary Care Trust (PCT) contracted Care UK to provide services at the UCC on 1 July 2011¹. The contract between Ealing PCT and Care UK is hereafter referred to in this report as ‘the UCC contract’.

5.4 The UCC contract started on 1 July 2011 and became operational on 6 July 2011. The contract expires on 2 July 2016.

5.5 Ealing CCG joined the Central London, West London, Hammersmith & Fulham, Hounslow and Ealing Clinical Commissioning Groups (CWHHE) collaborative on 1 December 2013. The collaborative involves the five CCGs working together and sharing resources. Posts such as those of the main directors (chief officer, chief finance officer, director of quality and safety) are shared across the CCGs, as is intelligence about providers. Each provider is allocated a lead CCG depending on location and patient flows. Brent CCG is the lead commissioner for LNWHT.

¹ PCTs and Strategic Health Authorities (SHAs) were abolished and Clinical Commissioning Groups and NHS England were formed as part of the NHS reorganisation on 1 April 2013. At this time the contract moved from Ealing PCT to Ealing CCG.

5.6 Care UK is the largest private provider of services to the NHS and social care sector in the UK. It has two main divisions - residential care services and healthcare. Healthcare delivers more than 70 services across the country including urgent care services such as NHS 111 services, 20 out-of-hours services including one minor injuries and illness unit and two urgent care centres in Ealing and Brent.

5.7 The UCC is open 24 hours a day 7 days a week, every week of the year. In 2014/15, 66,000 patients attended, about 60 per cent of all patients presenting for urgent and emergency care at Ealing Hospital. The other 40 per cent were navigated to the ED.

5.8 The UCC is a GP-led service that provides treatment and advice for a range of minor illnesses and injuries that require urgent and immediate attention.

5.9 Until recently Care UK employed a general manager who worked across Ealing and Brent Care UK urgent care centres and a service manager who worked beneath the general manager who worked solely at Ealing UCC. The general manager left in September 2015 and the service manager in November 2015. However, we refer to these individuals as the general and service manager throughout the report. A new service manager now has responsibility for the UCC. She is not referred to in this report.

5.10 The key functions of the UCC, as set out in UCC joint service reviews, are:

- *“Providing the right care, by the most appropriate person, in the right setting ensuring consistent responses at the first point of contact.*
- *Streaming non-urgent cases back to primary care.*
- *Primary care clinicians front-ending A&E. Access for A&E walk-in patients is via the clinical streamer.*
- *Facilitating unregistered patients to register with a GP practice.*
- *Providing health promotion and self-management education.*
- *Providing a seamless pathway to any further assessment required within A&E, including referral (if necessary) to a hospital specialist.*
- *Seeing and treating all patients within four hours of their arrival at the service.*

- *All patients medical management plans made within 60 minutes of the patient's arrival at the service*
- *All A&E referrals made within 120 minutes of registration."*

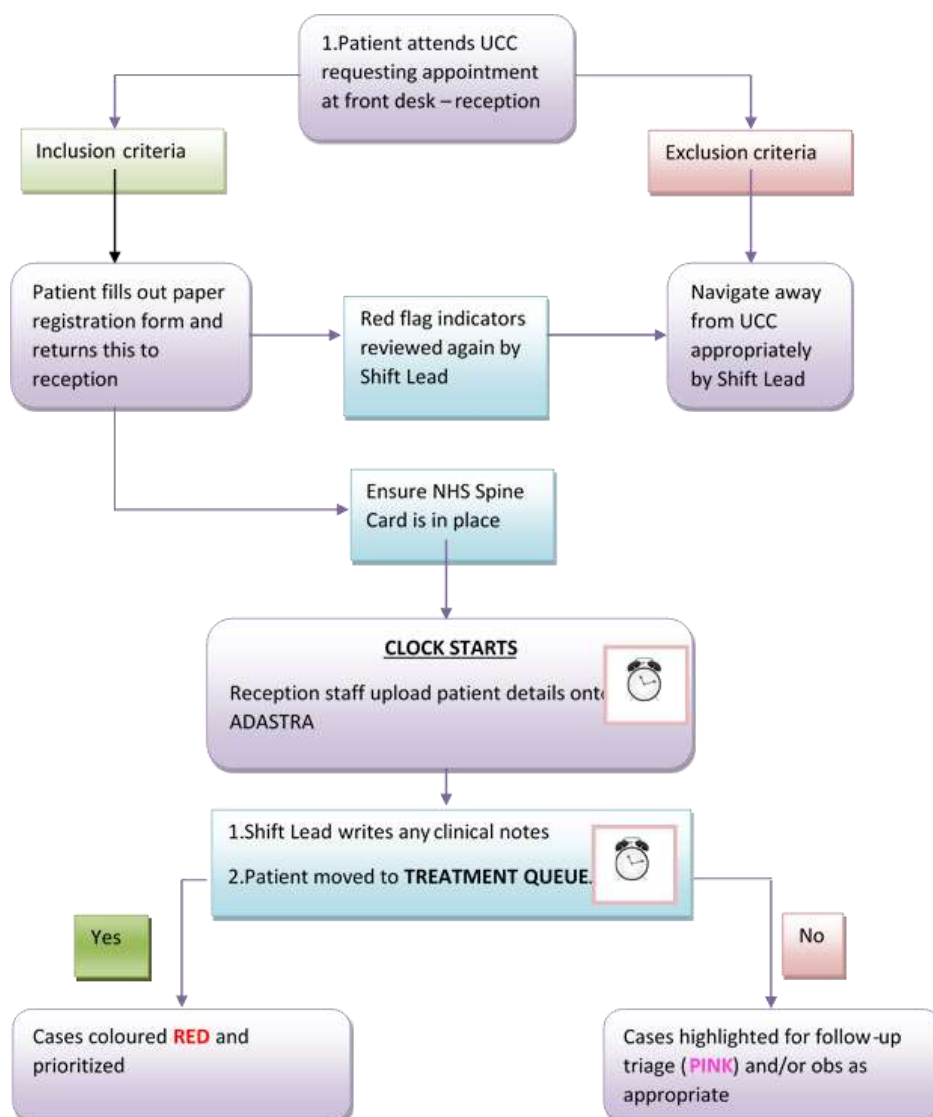
5.11 The CQC visited the UCC in October 2015 and raised no immediate concerns with the UCC. It has not yet published its findings. The previous CQC visit was on 14 May 2012 and it reported that the UCC was meeting all essential standards of quality and safety.

Patient pathway through the UCC

5.12 Patients arriving at the UCC and ED see a reception staffed by both ED NHS and UCC Care UK personnel. A sign tells patients in the first instance to report to the UCC navigator at one of the reception desks.

5.13 Patients are assessed and triaged by the navigator and sent either to the UCC or to the ED. The navigator is the Care UK shift lead for that particular day and an emergency nurse practitioner (ENP). Patients who are sent to the ED are asked to report to the ED receptionist.

5.14 When we visited the UCC and conducted our interviews, the patient pathways through the urgent care centre were as set out in figure 1 below. These were amended in October 2015 see 5.17.



5.15 Patients navigated into the UCC were asked to complete a registration form and return it to the Care UK receptionist at the reception desk next to the navigator. The receptionist uploaded the patient's information onto ADAstra and their electronically recorded time in the UCC began.

5.16 The receptionist then passed the registration form to the navigator, who checked the details on the registration form, asking for clarification from the patient if necessary. The navigator then put the patient in either an urgent or non-urgent treatment queue. Urgent patients appear in red on ADAstra and non-urgent patients are marked pink. The time of assessment is recorded.

5.17 The UCC changed to a paperless registration and navigation process on 12 October 2015. The receptionist now enters patient details directly onto Adastra in “*live time*” when they attend the reception - they are not required to fill in a paper form. Navigation takes place after this and the navigator records navigation outcome in real time.

5.18 Adult and paediatric patients have separate waiting areas and are called from there by emergency nurse practitioners (ENPs) who perform “*follow-up triage*” in which observations and history are taken and pain relief given where required. Urgent patients are seen before non-urgent patients. The ENP may treat or advise and discharge patients home or for follow up with their GP if appropriate. Patients not discharged return to the waiting room and are called from there for evaluation and treatment by the GPs.

5.19 The shift lead who performs navigation is also responsible for monitoring patients in the waiting area and for the flow of patients through the urgent care centre.

The four-hour target

5.20 The Department of Health requires that 95 per cent of A&E patients should be treated and either transferred, discharged or admitted within four hours of arrival.

5.21 NHS England defines urgent care centres as ‘type 3 A&E’ services and stipulates that they must report weekly attendances and breaches of the four-hour A&E target. The UCC reports this information daily to the CCG and to regional director for the London region, and the CCG reports to NHS England.

5.22 The Department of Health and Monitor¹ use the four-hour target as a central performance management measure for trusts.

¹ Health sector regulator.

5.23 Adastral records the data used to measure compliance with the four-hour target at the UCC.

5.24 The UCC data show that the UCC has consistently met the four-hour performance target over the year from July 2014 - July 2015.

National context

5.25 The *NHS Five Year Forward View* (2014) set out a redesign of urgent and emergency care services and new models of care. The NHS England *Emergency Care Review* details how these new models of care can be achieved through improving out-of-hospital services so that more care is delivered closer to home and hospital attendances and admissions are reduced. One of the key changes the *Emergency Care Review* sets out is *“Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.”*

5.26 NHS England have produced a suite of documents entitled ‘Transforming Urgent and Emergency Care Services in England’ and one of these is *“Safer, faster, better: good practice in delivering urgent and emergency care”* (July 2015). The guidance is clear that *“delivering safe and effective urgent and emergency care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do.”*

Local context

5.27 The original UCC contract expires in July 2016 but Care UK and Ealing CCG have agreed to terminate it in April 2016 so that the new Ealing UCC contract is in place by the time paediatric inpatient services at Ealing hospital close on 30 June 2016. Ealing CCG has begun the procurement process for the new contract. It will be an open to all applicants,

including the incumbent provider. In line with national thinking, the new specification focuses on a whole-system approach to providing urgent and emergency care in North West London and asks the new provider to integrate with other local services including the 111 service.

6. Investigation of the allegations raised in the ITV Exposure programme

6.1 In this section we review the evidence we have found about the allegations raised in the ITV Exposure programme. The allegations are as follows:

- GPs who work at the UCC are not fully trained for the job;
- the national four-hour target is not being accurately reported at the UCC;
- contractual KPIs are being manipulated at the UCC;
- the system for assessing patients on arrival at Ealing UCC is inadequate;
- patient's privacy and dignity is compromised when being assessed at the UCC reception;
- general failings in nursing and inappropriate waiting times for patients with potentially serious conditions (due to inadequate assessment);
- Ealing UCC is seriously understaffed and staffing levels put patients at risk during busy periods;
- there is a shortage of medicines at the UCC;
- a vulnerable patient was treated inappropriately by a member of staff at the UCC;
- Care UK did not ask for the reporter's references background checks or ID and she had unsupervised access to the whole UCC including the medicine cupboard;
- Care UK has fallen short of standards expected of a provider of out of hours (OOH) services to the NHS and there is an existing risk to patient safety; and
- underfunding of OOH GP services can lead to serious consequences.

The allegation: GPs who work at the UCC are not fully trained for the job

6.2 The ITV Exposure programme showed the lead audit GP explaining to the reporter that GPs do not know how to read x-rays or how to manage fractures. He says:

“... when you get new people here, unless they have done this kind of work as a GP in their community you're not looking at x-rays, you don't know how to manage fractures ... you have to keep an eye on them”

6.3 In this subsection we consider the recruitment and training of new GPs at the UCC, the supervision and management of GPs and x-rays.

National policy

6.4 The Department of Health guidance *National quality requirements in the delivery of out-of-hours services* (2006) states that providers must regularly audit a random sample of patient contacts and take appropriate action on the result. Regular reports should be made available to the PCT (now CCG).

“The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service.”

6.5 The *Urgent and Emergency Care Clinical Audit Toolkit*, produced by the Royal College of General Practitioners with the College of Emergency Medicines in 2010, applies across a wide range of urgent and emergency care situations, and supports the implementation of a system of routine clinical audit along all urgent care pathways. It is used to review individual clinician consultations systematically wherever patients with urgent care needs are assessed, including on the phone, face to face, in hospital or in the community.

6.6 It recommends random sampling and systematic review of each practitioner, looking at one per cent or four examples for each individual, whichever is the larger. If performance concerns are identified, this should be increased to four per cent, and new staff should have two per cent or eight cases reviewed. The results of the audit should be fed back at individual and organisational level.

Local policy

6.7 The UCC contract says:

“Before employing or engaging any person to assist it in the provision of the services under this agreement, the provider shall take reasonable care to satisfy itself that the person in question is both suitably qualified and competent to discharge the duties for which he is to be employed or engaged.”

“Clinical staff shall have the competencies to assess the need for, and order, diagnostics and interpret results. Relevant diagnostics to be capable of being accessed by the provider may include ... x-ray i.e. appropriate x-rays as agreed with imaging department.”

6.8 The GP job description states: *“To interpret investigations including blood results, ECG and x-ray. Training in x-ray interpretation will be provided.”*

6.9 The induction pack for new GPs (undated) includes guidance on navigation, documentation, prescribing, referral and x-ray management (among other topics).

6.10 *Guidelines on fracture management and referrals for UCC staff* (undated) - an appendix to the induction pack - describes the fractures that are commonly seen and the recommended treatment.

6.11 *X-ray guidelines* (undated) make reference to the Ottawa guidelines¹ for assessing clinical justification for x-rays of the knee, ankle or foot.

6.12 A Care UK Standard Operating Procedure entitled *SOP: X ray Reporting and Recalling Process - Ealing Urgent Care Centre* (2014) sets out processes for referral of x-rays to trust

¹ Ottawa guidelines help decide whether an x-ray is needed for a patient with foot/ankle, knee and neck pain to diagnose a possible fracture.

radiologists, management of radiology reports and recall of missed/mismanaged fractures. The SOP explains that x-rays are reported by a trust radiologist, mostly within 24 hours. It describes how the UCC GP working at night must compare each radiologist x-ray report to the patient notes to determine whether each patient was *“adequately managed on the day by the UCC clinician”*. If the x-ray report identifies a fracture that the UCC clinician has missed, the night GP must ask for the patient to be recalled and the incident recorded in the missed fractures log. Receptionists recall the patient the next day. The log is monitored daily and if the patient does not return within 48 hours another letter is sent to them explaining that it is *“now their responsibility to attend at their next convenience”*. It goes on to explain that an email is sent every Wednesday to the lead GP highlighting those recalls that failed to attend and the lead GP makes a clinical decision about whether the cases should be recalled again or their case closed.

6.13 The Care UK clinical audit policy (2013) states that *“those planning the clinical audit should consider seeking statistical advice about how to ensure that the sample is adequately significant, representative, clinically relevant and unbiased”*. The clinical audit results should be used to generate an action plan that sets out the areas needing attention and recommends actions required to address the identified issues. The policy also explains that clinical audit is a cyclical process that demonstrates that improvement had been achieved and sustained.

6.14 The Care UK competency assurance for clinical staff document, (September 2014), states that the unit or local medical director must be satisfied that all medical staff working within the unit are competent to perform the duties expected of them, and the clinical services manager or lead nurse is responsible for all other clinical staff. Directly employed Care UK doctors are required to participate in an annual appraisal process. Both employed doctors and locum doctors must show evidence of continuing professional development and maintain a portfolio of practice suitable for relicensing by the GMC and revalidation.

6.15 Care UK have a ‘Primary care agency new starter form’ which lists information to be checked including indemnity arrangements, registration, revalidation and performers list details and *“completed training / shifts using pathways”*.

What happens in practice

New GPs - recruitment and training

6.16 GPs who work in the UCC either have substantive contracts or are self-employed medical practitioners (SEMPs). Five substantive GPs and 15 SEMPs have been approved by UCC managers to work at the UCC. Ten GPs work each day.

6.17 The lead GP works three clinical days a week and two days a week non-clinical as well as two hours at the end of each day. The non-clinical time is when he works on his managerial and leadership responsibilities, including organising teaching, interviewing new GPs, giving them inductions, reviewing Datix¹ incidents, responding to patient complaints and dealing with personal staff issues.

6.18 The audit lead GP told us he shared some leadership responsibilities with the lead GP but also had responsibility for clinical audit across the Brent² and Ealing UCCs. We refer throughout to the lead GP and the audit lead GP as the lead GPs.

6.19 The general manager told us that when a GP applies to work at the UCC, he and one of the lead GPs review the CV, the lead GPs decide whether the GP meets the requirements to work at the UCC and then they decide whether to invite the GP for interview.

6.20 The service manager told us she checked GP qualifications as part of the recruitment process. Care UK record GMC status in a compliancy log for UCC GPs. The UCC GP and ENP training log sent to us in August 2015 sets out compliance with a number of qualifications and training courses:

- Advanced life skills (ALS) (or equivalent)
- Advanced paediatric life support (APLS) (or equivalent)

¹ Patient safety and risk management software for healthcare incident reporting and adverse events

² Brent UCC is also run by Care UK.

- Red Dot trauma course for radiographers (one day course taught by radiographers at Northwick Park Hospital)
- Practical obstetric multi-professional training (Prompt)
- Safeguarding children level 3
- Basic life support (BLS)

6.21 Care UK told us that qualifications in the log were desirable on application but not essential because training was given. Of the 20 GPs listed, the following do not have or it is not clear if they have the following qualifications:

- four ALS;
- seven APLS;
- five Red Dot course;
- seven prompt; and
- five safeguarding.

6.22 Care UK told us that in February 2015 UCC managers had sent 10 of their substantive staff, including four GPs and six ENPs, on a 10-week course at Imperial College for out-of-hours clinicians. In addition four self-employed GPs also went of their own accord. However, the training log records that just three of the substantive GPs, three ENPs and one SEMP attended the course.

6.23 A GP told us the course was useful and covered the full scope of scenarios encountered in the UCC. We asked the UCC for the course outline and/or material but it was not provided. The service manager also explained that Imperial had run the course only once and there were no firm plans to run it again. It is not mandatory training for GPs working in the UCC.

6.24 The governance manager for Care UK's London region told us that recently a new learning management system had been introduced that electronically monitored compliance for all Care UK staff against mandatory training modules. She told us she thought the gaps in training at the UCC were a result of the process of embedding this system.

6.25 Care UK sent us the most recent integrated governance report for the UCC dated October 2015 (report explained in section 8) which risk rated statutory and mandatory training at the UCC as red in September 2015 and green in October, using a Red Amber Green (RAG) risk rating. This metric only relates to substantive GPs and not SEMP's.

6.26 GPs applying to become substantive GPs or SEMP's at the UCC are interviewed by one of the lead GPs and the general or service manager. The lead GP told us the interview included an assessment of clinical competencies and questions about previous experience, specifically in emergency and out-of-hours settings, in orthopaedics, management of children, interpretation of x-rays and ECGs and management of minor injuries (e.g. suturing).

6.27 The service manager told us they might employ a GP because their *"personality, drive and enthusiasm to learn is appropriate for UCC"* and they ensured they were appropriately supported until they attained the skill level needed to work at the UCC.

6.28 Once a GP started, they undertook a two-week induction programme when they sat in on some of the lead GP's patient sessions. A GP told us the induction was good and that he was eased into the job. He spent his time sitting in with other GPs, ENPs and health care assistants (HCAs).

6.29 The lead audit GP told us that a GP's first shift took place during the day when there were plenty of people in the department so that they were well supported. He told us that he and the lead GP audited a sample of the GP's notes in the first month they started. We asked for but were not provided with any audit reports for this sampling process. However Care UK confirmed that a new process was introduced in October 2015 whereby the lead GPs will audit four case notes from the new GP's first shift. The lead GPs will discuss any concerns or training requirements with the GP following the audit.

6.30 The lead GP told us that agency GPs rarely worked at the UCC. Those who did were well known to UCC managers. Agency GPs were not interviewed until recently. In the *"last six months"* they had begun to undergo a brief clinical assessment, usually over the phone but sometimes in person, and an induction.

6.31 Fortnightly clinical education meetings take place for all clinical staff, with teaching sessions on various topics, for example x-ray interpretation, controlled drug prescribing, emergency gynaecology, management of acute asthma and missed fractures.

6.32 The CCG does not require the UCC to provide evidence of the level of training and competency of staff at the UCC. CCG managers we spoke to were clear that all the providers they contracted were responsible for ensuring staff were qualified and adequately skilled.

Comment

The interview and recruitment process is thorough but the training log shows low compliance with core training courses. Most of the GPs have worked at the UCC for some time. This suggests that the process for ensuring GPs undertake training has not been thorough. Care UK explained that the introduction of a new learning management system should ensure the UCC is fully compliant with mandatory training. This is supported by the October 2015 integrated governance report that RAG rated the statutory and mandatory training as green. However the metric does not relate to SEMP's who make up the majority of GPs who work at the UCC.

The Imperial 10 day out-of-hours course has clearly been beneficial to GPs but it has been run only once and therefore any new GPs will not be able to attend the course unless or until it is run again.

The induction pack for new GPs, including guidance on x-ray management, is comprehensive but undated.

Not all GPs have all the necessary skills and training at the outset of their induction but the induction process is thorough and new GPs sit in with the lead GPs. The lead audit GP told us that he and the lead GP audit new GPs notes in the first month they work in the UCC however we have seen no documentary evidence to support this. Care UK have described a new process, introduced in October 2015, whereby the lead GPs

audit four sets of case notes from a GPs first shift. This will be a useful additional layer of assurance.

We support the CCG argument that it is the responsibility of the provider to ensure their staff are adequately trained and skilled.

Recommendation

R1 The UCC general manager should ensure within the next three months that all UCC GPs, including self-employed medical practitioners (SEMP), are fully compliant with statutory and mandatory service requirements.

Supervision and management of GPs

6.33 Our clinical GP adviser asked the UCC to provide the GP rota for the week commencing 1 August 2015, with the number of years experience of working at Ealing UCC for each of the GPs on the rota so that we could assess the experience of the GPs. The week was chosen at random. It showed that all five substantive GPs worked that week as well as 12 SEMPs and one agency GP. The substantive GPs had between one and four years' experience at the UCC and most of the SEMPs had between two and four years. Two had just nine months' experience but they were always working with more experienced GPs. The agency GP had three years' experience.

6.34 The lead GPs told us that they informally supervised and oversaw the other GPs daily.

6.35 GPs are expected to have an annual appraisal of all their professional practice by an accredited GP appraiser as part of their revalidation requirements with the GMC. The UCC does not keep a record of appraisals and revalidation for GPs nor does Care UK monitor them centrally.

6.36 Care UK directors told us the lead GPs at the UCC were responsible for ensuring that GPs working at the UCC had up-to-date appraisals that should be discussed at the Personal Development Reviews (PDRs). Care UK confirmed that it was the responsibility of the individual clinician to ensure that their appraisal was up-to-date. However Care UK also told us that they can request to see appraisal documentation if there are any concerns about a clinician's performance.

6.37 The medical director for primary care explained that the Care UK appraisal and revalidation policy states that GPs must share the output of their appraisal with Care UK but that in practice GPs could be reluctant to provide this information because their Responsible Officer (RO) sat outside Care UK.

6.38 The lead GP told us that he conducts PDRs on a yearly basis with GPs - touching base with them, seeing how they are and what their aspirations are over the next 12 months. He confirmed that all PDRs for contracted clinicians are up to date but we have not seen any documentary evidence (such as a log setting out PDR and appraisal dates and outcomes for each UCC GP) to support this. One of the UCC GPs told us that in practice GPs met the lead GP more frequently.

6.39 The lead GP told us that if there were performance concerns about a GP he would sit in on their clinical sessions and review their clinical conduct, audit their case notes and prescribing behaviours and meet them one to one. We have seen an anonymised review of 11 cases for one GP. This was conducted by the medical lead at Ealing UCC following an SI and identified a range of concerns. The GP was subsequently removed from the rota.

6.40 As well as through audit performance, concerns reach the lead GPs via Care UK or ED colleagues, complaints and Datix incidents.

6.41 The lead audit GP uses the *Universal and emergency care clinical audit tool template* (Royal College of General Practitioners and College of Emergency Medicine (CEM)) to audit GP documentation. He audited five cases for each of the substantive GPs for the period 2 to 28 February 2015. This is a 0.61 per cent sample. He produced an audit report in March 2015 with an overall score of 81 per cent.

6.42 The lead audit GP explained the reason that only substantive GPs were audited:

“outcomes and action plans are easier to disseminate to substantive staff and therefore I would expect using only substantive clinicians for the audit may potentiate any gains from teaching/training.”

6.43 The audit report set out the areas of weakness (history taking, reason, consultation conclusion and patient empowerment, red flag documentation) and strengths (documenting consultations, management, prescribing, assessment and treatment). The action plan to address areas of weakness included clinical meetings, group emails and individual feedback.

6.44 The audit before the February 2015 audit was conducted between 1 January and 31 March 2014. The methodology was slightly different. A random sample of 30 cases was taken from substantive and SEMP staff. This is a 0.2 per cent sample. The report says:

“One particular GP was identified as performing below average and will be given individualised face-to-face feedback. The clinician who was seen to be struggling previously has been audited separately.”

6.45 The action plan is the same as the February 2015 audit. The overall score 75 per cent.

6.46 In July 2015 Care UK set up a Clinical Audit and Effectiveness Group (CAG) to assess audit methodology, quality, outcomes and learning in its services. Details of Care UK’s governance processes related to audit are described in section 8.

6.47 The governance manager told us that the CAG had decided that the UCC should be auditing documentation and x-rays more frequently than six-monthly because of the number of contacts that they had.

6.48 We have not seen or heard any evidence that GP documentation audits are sent to the CCG or discussed at contract review meetings.

Comment

The rota we saw shows that there were always GPs with more than two years' experience at the UCC working in that week. The level of supervision for new GPs in the UCC is appropriate.

Care UK expects GPs working at the UCC to have up-to-date appraisals and it is the lead GPs' responsibility to check this at a GP's PDR. However there is no record that PDRs have taken place nor that GPs working at the UCC have up-to-date appraisals. This should be remedied and we make a recommendation about it.

The lead GPs told us that if a GP causes them concern they will put in place a system of monitoring and we have seen evidence that this happens.

The lead audit GP samples substantive GPs' documentation from between one and three months. The frequency and sample size is lower than recommended in national guidance. He does not audit SEMP's, who make up most of GPs working at the UCC, and so cannot be assured of the quality of their consultations/documentation.

The action plan is the same for both the audits we reviewed and there does not appear to be significant improvement between the two audits. We therefore query whether the actions set out are effective.

The CCG does not review these audit reports in any forum. We would expect the CCG to critically assess these audits in the contract review meetings.

We review the Care UK internal processes for monitoring the quality of audits in section 8.

Recommendations

R2 The UCC lead GPs should ask within the next month for evidence of up-to-date annual appraisals (as required by the GMC for revalidation) for all GPs working in the UCC and keep a record of that documentation on each personnel file.

R3 The UCC lead audit GP should audit one per cent of all patient consultations for all GPs notes every three months in accordance with national guidelines.

X-rays

6.49 The lead audit GP told us he had made the comment on the ITV Exposure programme that GPs were not able interpret x-rays. He said the comment had been taken out of context and was not directed at UCC GPs: he had been referring to GPs in the community who could not interpret x-rays because they were not routinely required to review them, instead receiving written reports about them. The Hardcash reporter said that she thought that the lead audit GP meant GPs in general - in the community and some in the UCC - cannot read x-rays. The Hardcash producer told us that it is clear from the reporter's discussions with the lead audit GP that he had meant that some GPs in the UCC had not had training in how to read an x-ray.

6.50 The lead audit GP explained that the UCC put assurances in place to try and ensure that someone coming straight out of general practice into the UCC could interpret x-rays. He explained that they asked all GPs starting work at the UCC to attend the Red Dot course and present a certificate of completion. The service manager told us that all GPs and nurses attended the Red Dot course, although the training log shows that five had not yet completed the course.

6.51 Care UK told us that all substantively employed GPs and ENPs have attended the red dot course. However SEMP are advised to attend the course if it is deemed that a refresh is needed at their interview. They also confirmed that *"ENPs who are expected to discharge*

minor injury cases will have had specific x-ray interpretation teaching as part of their training.”

6.52 A GP told us that he had been worried about whether he had enough experience to interpret x-rays and had mentioned this during his interview. The lead GPs assured him that he would learn on the job and that he could do the Red Dot Course.

6.53 The GP went on to tell us that he did the Red Dot course the month he started but this would not be possible for every new starter because of the high demand and because the course did not take place often. He told us it was a good course and taught participants to spot subtle fractures otherwise likely to be missed.

6.54 The lead audit GP explained that having the trust radiologist report every x-ray (as described in the SOP) was a further safety net.

6.55 An Ealing hospital consultant radiologist told us that UCC GPs occasionally came to the radiology department for advice on x-rays but his contact with them was largely confined to receiving their x-ray films and reporting them. He told us he produced 50 to 100 reports for the UCC every day.

6.56 A log of X-ray recalls in 2015 showed that between 15 and 31 patients have been recalled because their fractures were missed each month.

6.57 One of the UCC GPs said there was great camaraderie in the department during the day and that everybody was approachable. He was happy to approach other GPs and ENPs in the department, as well as the orthopaedic or ED registrars for help with x-ray interpretation. He said everybody was happy to help. He told us it was commonplace to get second opinions about x-rays and that *“you have to know the limit of your own capability.”* He added *“I don’t think I’ve ever been in a position where I’ve not known where to get help from when I’ve not known what to do.”*

6.58 The desktop review the CCG undertook in July 2015 reviewed complaints received by the CCG about the UCC between April 2014 and March 2015. Six patient complaints

related to fractures, including two missed and two mismanaged fractures, one person had expected an x-ray but did not have one and one diagnosis found a fracture when there was none.

6.59 We reviewed the UCC concerns and complaints log from January to June 2015 and found two complaints in June 2015 about fractures: one had been missed and one person complained about management and follow-up of a fracture.

6.60 Healthwatch Ealing complaint and compliment log January to August 2015 records one complaint about a missed fracture.

6.61 The GP audit lead for the UCC audits 30 x-rays every six months. He assesses x-ray interpretation and appropriateness. We have seen three audit reports none of which described any missed fractures.

6.62 A report in February 2015 set out an audit of 30 cases out of a possible 2,803 x-rays between 1 November 2014 and 31 January 2015 (1.1 per cent sample). The report contradicts itself and also refers to a *“period of 3 months June 1st 2014-Jul 30th 2014”*.

6.63 The February 2015 report states that *“sensitivity remains high”* and *“specificity has improved”* with *“less inappropriate cases in UCC”*. The audit did not find any evidence of missed fractures. The GP audit lead attributes good performance and improvement to teaching around Ottawa guidelines and *“incorporation into red folders¹”*.

6.64 The report also goes on to outline other methods of learning and development including:

- individual feedback to clinicians if they miss a fracture;
- ongoing x-ray teaching at Brent UCC with a radiographer; and

¹ Red folders are UCC folders that contain pathways and guidance for clinical staff

- attending the out-of-hours clinicians Imperial course, which includes specific teaching on x-ray interpretation and fracture management.

6.65 A report in July 2014 says 30 out of 2,331 x-rays were reviewed (1.3 per cent sample) from the “period of 3 months June 1st 2014-Jul 30th 2014”. There were no missed fractures recorded by the audit.

6.66 X-ray audits are sent to the CCG and discussed at the contract review meetings. The minutes refer only briefly to missed fractures and the appropriateness of x-ray referrals. At the meeting in January 2015 the lead audit GP described a one per cent sample of fracture patients from July through to September 2014 and described the overall outcome of the audit as very positive. We have not seen an audit for this period.

Comment

On balance, we believe the lead audit GP’s comment to the undercover reporter about GPs not being capable of interpreting x-rays was referring to GPs when they start to work in the UCC because they have not had to interpret x-rays in the community. The lead audit GP told the reporter they “have to keep an eye on them”. The UCC has systems to help GPs coming out of the community to interpret x-rays, including written guidance on fracture management; induction and requiring all substantively employed GPs to attend the Red Dot radiology course. However, we heard that the course is infrequent and oversubscribed so GPs may not be able to attend before starting work at the UCC. It is not mandatory for SEMP’s to attend the red dot course.

GPs in the UCC are supported to manage x-rays that they are unsure about and the system of radiology checking x-rays is rigorous. We do not know the total number of UCC patients with fractures each month and so cannot make a comment about whether 15 to 31 recalled patients a month is acceptable. However it is important that the lead GPs review the missed fractures in order to determine whether any should have been obvious to spot. Any such fractures should be analysed and individual feedback and training given to clinicians as necessary.

The lead audit GP conducts x-ray audits every six months but the sample of x-rays chosen for audit (30) is taken from between three and two months within that period. This gives a false impression that the sample size is around 1 per cent when actually it is between 0.33 and 0.5 per cent of fractures. Errors in the dates quoted in the audit reports suggest a less than rigorous approach.

The audits found no missed fractures but the nine complaints related to fracture management between April 2014 and August 2015 indicate that the number of cases being audited may be too small to give an appropriate level of assurance.

The CCG does not assure itself about the quality of the x-ray audits. We discuss this further in section 7.

We discuss ENP, HCA and receptionist competencies in later sections.

Recommendations

R4 UCC managers should require all practitioners who interpret x-rays in the UCC to attend the Red Dot or equivalent course within the next two months if they have not already done so.

R5 UCC managers should assure themselves within the next two months that the frequency and sample size of x-ray audits is sufficient so they are assured that all practitioners who interpret x-rays are competent to do so.

The allegation: the national four-hour target is not being accurately reported at the UCC

6.67 The ITV Exposure programme showed a GP saying he routinely discharged patients on the UCC computer system before he had finished dealing with them.

6.68 In order to determine whether the four-hour target is being accurately recorded and reported at the UCC, we examine whether the following is in line with national policy:

- recording the time of arrival;
- recording the time of departure; and
- UCC reporting (including exception reporting) of the four-hour target.

National policy

6.69 *NHS England Emergency care weekly situation report (2012)* defines the start of a patient's time in any ED as:

"The clock starts from the time that the patient arrives in A&E... the time of arrival should be recorded by the clinician carrying out initial triage/assessment or A&E reception, whichever is earlier...For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier."

6.70 The same report defines the end of the time in an ED as when the patient is:

- *"Discharged home. Time of discharge home is defined as when the patient's clinical episode is finished, unless they are waiting for hospital arranged transport or social care/social service support. In these cases, the time of departure is the time the patient actually leaves the department. Patients awaiting family or 'private' transport or who wish to make their own arrangements should be considered discharged once the clinical episode is complete whether or not they have actually left the department.*
- *Transferred. Transfer is defined as transfer to the care of another NHS organisation or other public/private sector agency (for example social services). Time of transfer is defined as when the patient leaves the department.*
- *Admitted... Time of admission is defined as the time when such a patient leaves the department to go to:*
 - *An operating theatre*

- *A bed in a ward*
- *An x-ray or diagnostic test or other treatment directly en route to a bed in a ward ... or operating theatre. However, leaving A&E for a diagnostic test or other treatment does not count as time of admission if the patient then returns to A&E to continue waiting for a bed.”*

6.71 The guidance does not set out any exceptions.

6.72 Ealing UCC is a type three ED according to the guidance.

6.73 The guidance explains that if a patient is transferred to another ED on the same hospital site but which is run by another organisation, the “*clock does not stop*”. It stipulates that the receiving organisation must report the combined wait, and if the patient’s overall stay exceeds four hours, then both organisations should record the breach in their situation reports (sitreps). The guidance also provides that where the type 3 service is run by an independent sector provider on the same site as an ED service, it is permissible for only one organisation to report ED breaches as long as there is an agreement in place between the parties.

Local policy

6.74 Figure 1 in section 5 of this report sets out the patient pathway through the UCC. A patient’s time of arrival is recorded when the receptionist starts to upload their details onto Adastra.

6.75 Two contractual Key Performance Indicators (KPIs) relate to the four-hour target:

- Four-hour A&E wait: the percentage of UCC referrals to the ED (excluding those patients that are navigated immediately to the ED) that breach the four-hour A&E standard should not exceed two per cent.
- Specialist referral: the percentage of patients referred and transferred to acute hospital specialists (including the ED) within 120 minutes (excluding any failures

solely attributed to any third-party provider of such specialist referral services) should not exceed 90 per cent.

6.76 Neither the contract nor the KPI schedule mentions UCC reporting of the four-hour standard or exceptions to four-hour breach reporting.

6.77 Until November 2015 there was no local policy for recording or exception reporting of the four hour waiting time target. Since November 2015 the UCC has started to use a daily breach report that includes local reporting definitions, process and exceptions. The following are exceptions described in the report:

- *“discharged or DNA”*
- *“Cases where an onward referral service has attributed to breach - await mental health services”*
- *“Cases where an onward referral service has attributed to breach - await imaging service, delay over 60 minutes”*
- *“Cases awaiting referral to other service, but no response within 60 minutes”*

6.78 The report states that these exceptions should only apply to contractual reporting and not to the national four hour waiting time target.

What happens in practice

The time of arrival

6.79 Staff we spoke to told us that the time of arrival at the UCC is recorded when the receptionist fills in a patient’s details on Adastra. A patient may have been in the department for some time while being navigated and completing their registration form.

6.80 However, the new system for registration and navigation at the UCC introduced in October 2015 means that patient details are added onto Adastra as soon as they arrive at

the UCC. We have not observed this new process as it was introduced after our observations and interviews took place. However we have been sent a flow chart setting out the process.

Comment

The old system of navigation and registration meant that patients may have waited in the UCC for some time before the receptionist puts their details onto Adastra and therefore before their time of arrival is recorded. This was not in line with national policy. The new process introduced in October 2015 is likely to remedy this.

The time of departure

6.81 We spoke to the GP who was shown telling the undercover reporter that he routinely discharged patients on Adastra before he had finished dealing with them. He told us that his comments had been taken out of context and that he was trying to “*sound amusing to a colleague*”.

6.82 He told us that he did not discharge patients from Adastra until their treatment and care was complete. This GP and other GPs we spoke said there were specific circumstances when a patient might be recorded as discharged on Adastra before they have left the UCC. These included when they had finished treatment and were waiting for something that would not change the management of their care. The examples they gave included waiting for a call about follow-up care for a patient, waiting for confirmation of a clinic appointment (such as the fracture clinic) or waiting for medication.

6.83 The CCG acting managing director told us that the CCG was reviewing the national guidance on this matter.

6.84 The lead GP felt these would be only “*isolated instances*” and that “*in the vast majority there’s no culture where we close off cases prior to discharge*”.

6.85 Our review of the UCC data for the past year supports this assertion. It shows no pattern of treatment time being recorded later than discharge.

Comment

Staff we spoke to consistently told us that patients were not taken off the system before their episode of care was complete. The data appear to support these assertions. However, they also told us that patients might be discharged off the system while waiting for medication or for confirmation of follow-up care. This correlates with the evidence in the Hardcash programme.

The national guidance is not clear about whether this is good practice but it is our view that at least those patients waiting for medication should not be discharged because they may need further advice.

Patients should not need to remain in the UCC waiting room for more than a few minutes after being recorded as discharged on Adastra to avoid the risk that they will be forgotten.

Recommendations

R6 The CCG should clarify the guidance from NHS England relating to the point at which a patient's waiting time ends and agree the process with the UCC within the next two months.

Reporting four-hour breaches

6.86 The service manager told us that she sent a daily situation report and performance report to the CCG and copied her email to the ED. The report includes the number and percentage of four-hour breaches and late referrals to ED (any referrals made over two

hours). She also sent this information to the Care UK regional director. She told us that the UCC and ED report their joint breaches to NHS England weekly.

6.87 The general manager explained three scenarios when a patient is cared for in both the UCC and ED and they breach the four-hour target:

1. If the patient is referred to the ED within two hours (as per the contractual KPI) and the patient subsequently breaches, ED report the combined wait and the breach and UCC do not report it
2. If the patient is referred to the ED between two and four hours and the patient subsequently breaches, the ED record the breach and UCC do not. However, the UCC fail their contractual KPI and the ED can cite the reason for the breach as UCC delay
3. If the patient breaches four hours in the UCC before being sent to the ED, the UCC will report the breach

6.88 He explained that the combined wait should be reported once or the hospital would be double-counting breaches.

6.89 The lead GP explained that if a patient breached in ED after spending time in the UCC then a joint UCC/ED breach would be reported. However, he did not think that in circumstances where a patient had been sent to the ED by the UCC in ‘good time’, for example within one hour, and they subsequently breached because they were waiting for a specialty that it was acceptable to record this as a UCC breach.

“We get a list of all these breaches every day and when we cross-reference them with our patients we can demonstrate that we sent them in very good time, so any breaches that occurred downstream were attributable to the hospital specialty in the ED Department.”

6.90 The CCG acting managing director told us that the trust had raised this issue with the CCG and that the CCG had raised it with the pan London Contract Delivery Group. They in turn had reported to the CCG that the UCC’s approach in not reporting the breach was

consistent with other providers/services. At the time of our interviews the issue had not been resolved.

Comment

One of the contractual KPIs stipulates that the UCC should refer patients within two hours to the ED so that the ED can meet the four-hour target but neither the contract nor KPI schedule refer directly to UCC reporting of the four-hour target. Given that it is a national standard, we think it should also be a contractual KPI.

National guidance is clear that where patients are treated at a UCC and ED on the same site, both departments should report any breach, except where the UCC is run by an independent sector provider. In these circumstances it is permissible for just the ED to report breaches as long as this has been agreed between the parties. The UCC report only those patients who spend more than four hours in the UCC. The CCG are aware of this and have found it consistent with the way other services report. We make a recommendation about this below.

Recommendation

R7 The CCG should agree reporting requirements of the four-hour waiting time target with the UCC and ensure that reporting is in line with national policy within the next two months.

Exception reporting

6.91 The acting managing director of Ealing CCG told us that Care UK had recently informed the CCG of a clause in the contract that enables them to stop the four-hour clock if a patient goes for an x-ray. The clock is restarted when they come back to the department. They told us that they were not aware of this happening until August 2015.

6.92 We have not been able to find a clause in the contract that refers to exception reporting the four-hour target.

6.93 All UCC staff we asked told us the clock did not stop for x-rays.

6.94 The lead GP explained that in exceptional circumstances when a patient had been referred to the x-ray department (for example after half an hour in the UCC) and the patient was delayed in the x-ray department for a significant time (for example, three hours) and the patient subsequently breached then the UCC might report the case as an exception rather than a breach.

6.95 The service manager told us that the KPI performance schedule was followed and that other exceptions included *“patient DNA without informing the staff and the agreed exception reporting for the psych pathway, where the aim is for patients to be seen by the MH team, within 1hr of referral”*. She referred us to an email from the lead GP to those working in the UCC on 24 November 2014 explaining the new psychiatric pathway. The email mentions nothing about any exclusion from four-hour target.

6.96 The lead GP told us that mental health patients could wait in the department for up to 10 hours for a bed:

“Yes, that gets reported as we referred the patient in good time but the delay was on behalf of the specialty.”

6.97 The lead audit GP explained patients who did not answer when called because they had either gone home or left the UCC for a significant time would be reported as an exception. He added:

“Also, the other types of patients we exception report are where there’s a delay in other areas of the system. For example, if I’ve tried for half-an-hour to bleep orthopaedics and I can’t get hold of them, the delay really is outside of the UCC

and I think we exception report those patients as well and we document what times we bleep, etc., so that's very clear to see."

6.98 We have seen an *"Ealing Exclusion KPI Spreadsheet 2.5 240 Mins"* for January and February 2014, one of the papers submitted for discussion at the contract monitoring meeting on 25 February. Comments next to patients excluded include:

- *"DNA while in UCC"*
- *"Patient surge between 4-6pm"*
- *"3 mins over time - patient surge between 4pm - 6pm"*
- *"Prescription given at 2h and D/C but case not closed"*
- *"only one GP overnight - backlog of patients"*
- *"2 mins over 4h, GP would be writing notes in this time"*
- *"language problems"*

6.99 We asked the CCG acting assistant director of unplanned care who was at this meeting if she could recall the conversation and she could not. The service manager (who was not at the meeting) told us that this form of spreadsheet was no longer used and she could not explain the comments.

6.100 The service manager explained that the issue of exception reporting had now been resolved in that the Care UK regional director had confirmed that if there was a delay of one hour or more caused by a third party, the UCC could report them as exceptions both for their KPIs and the national four-hour target.

6.101 Care UK advised that the new four hour reporting policy introduced in November 2015 is now applied on a daily basis and a breach report including exceptions to the contractual KPIs is sent to the CCG. They confirmed that exceptions are not now applied to the four hour national reporting figures. They also told us that the trust reports combined ED and UCC figures against the four hour target and so Care UK does not know whether the UCC figures include exceptions.

Comment

Since November 2015 the UCC has followed a policy for reporting exceptions against the four hour target and has confirmed that these exceptions should only apply to contractual reporting and not to the national four hour waiting time target. However Care UK does not know whether the trust uses UCC data that includes exceptions when reporting combined ED and UCC breaches of the four target.

Recommendation

R8 The CCG should confirm that when reporting the combined ED and UCC breaches the trust use UCC data that does not include any exceptions to the four hour target within the next month.

The allegation: contractual KPIs are being manipulated at the UCC

6.102 The ITV Exposure programme alleged that the specific KPIs related to the initial clinical assessment were being manipulated. We therefore examined only the reporting of these specific KPIs.

6.103 The programme also alleged that Care UK received less money from the CCG if it failed to meet the contractual KPIs.

National policy

6.104 The Department of Health guidance *National quality requirements in the delivery of out-of-hours services* (2006) describes a definitive clinical assessment as:

“... an assessment carried out by an appropriately trained and experienced clinician ... which will result either in reassurance and advice, or in a face-to-face

consultation ... ”

“Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre*
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre”*

6.105 *Standards for children and young people in emergency care settings (2013)* developed by the Intercollegiate Committee for Standards for Children and young people in Emergency Care settings sets the standard for assessing children in out-of-hours settings:

“All children or young people attending an emergency care setting must be visually assessed immediately upon arrival and receive an initial triage assessment within 15 minutes of arrival or registration.

If the waiting time for full clinical assessment exceeds 15 minutes, an interim, brief assessment by a competent and appropriately trained nurse or doctor should take place. This assessment should include recognising the sick child, identifying serious illness or injury (using a standardised system, e.g. The Manchester Triage System), completing a pain score and include an assessment of child protection or at-risk status.

... Relevant treatments/investigations including imaging should be initiated at triage (i.e. within 15 minutes of arrival)”

“Analgesia is dispensed for moderate and severe pain within 20 minutes of arrival.”

6.106 *The Royal College of Emergency Medicine Audit of Vital Signs 2015-16* is a template for clinical audits of vital signs in children attending EDs inviting submission of data to the

RCEM by 31 January 2016. It invites the capture of the following data; case mix; vital signs, abnormal vital signs; repeat measures and discharge outcomes. The vital signs listed are temperature, respiratory rate, heart rate, oxygen saturation, Glasgow coma score and capillary refill time.

Local policy

6.107 The UCC contract sets out the navigation process and expected timings:

“The Provider shall undertake an initial assessment of Patients that self present at the Unscheduled Care Centre Premises within five (5) minutes after the Patient’s arrival at the Unscheduled Care Centre Premises to determine whether they should be navigated to the Primary Unscheduled Care Service (which is expected in the majority of cases) or the Emergency Department.”

6.108 It explains that the purpose of the initial assessment is to confirm whether the patient has been correctly navigated.

6.109 The UCC contract sets out the “key areas of focus and importance” in 26 KPIs. The KPIs measure UCC performance and quality through various components of the patient pathway through the service. Two KPIs relate to the initial clinical assessment:

- *“Percentage of adult patients who have their initial brief clinical assessment and navigation within 20 minutes.*
- *Percentage of children who have their initial brief clinical assessment and navigation within 15 minutes.”*

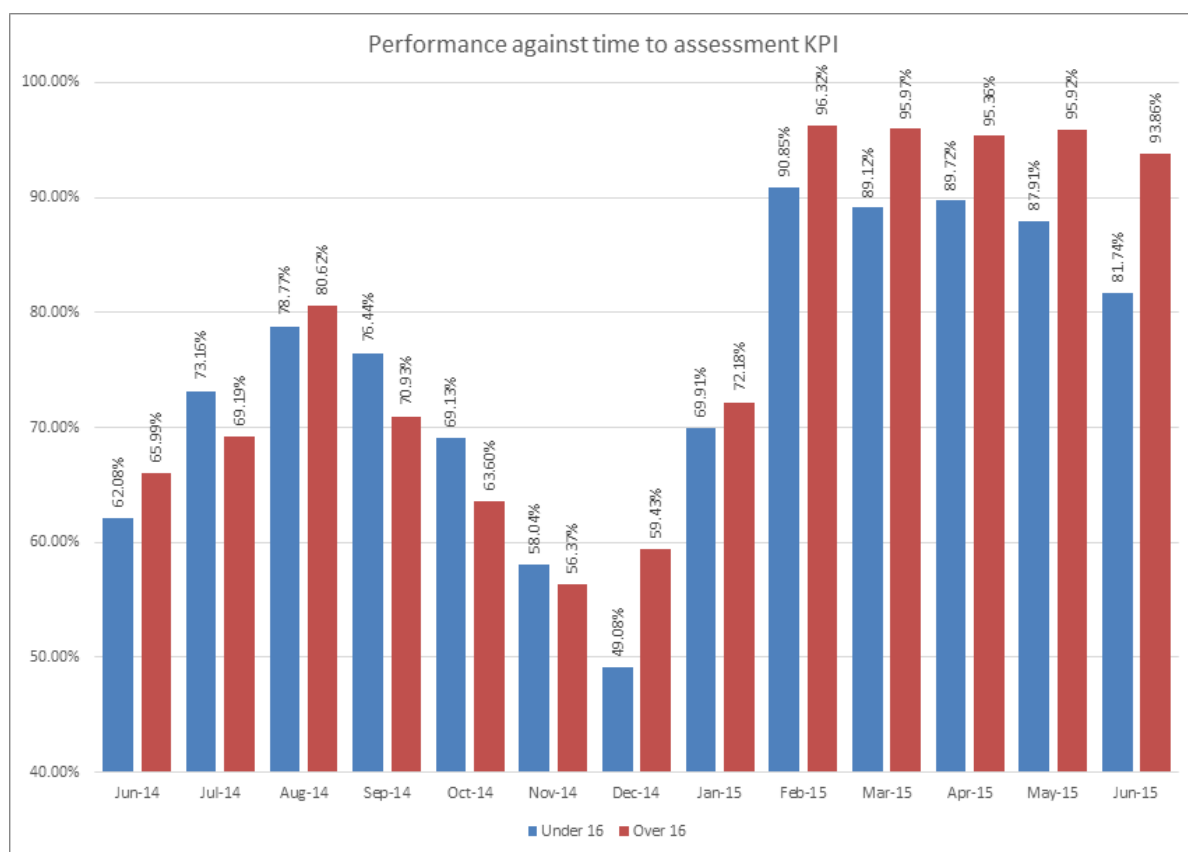
6.110 If the UCC meets this KPI (referred to in the contract as band A), more than 98 per cent of patients are treated within these times and the UCC is paid 100 per cent of the contractual payment for the patients. The minimum acceptable level of performance (band B) is that more than 90 per cent of all patients are treated within these limits and the UCC

is paid 75 per cent of the contractual amount. Performance below 90 per cent is unacceptable and will result in 25 per cent payment.

6.111 The UCC contract provides that the CCG can apply financial penalties to the UCC for not meeting KPIs.

What happens in practice

6.112 UCC data show that performance against the adult and child clinical assessment KPIs significantly improved since February 2015.



6.113 A contract management meeting in January 2015 discussed UCC underperformance against the clinical assessment KPIs.

6.114 The acting managing director of Ealing CCG told us that the CCG then examined the clinical assessment time-stamping process in urgent care centres across North West London. The CCG found that other urgent care centres were time stamping after the initial quick assessment, whereas Care UK were time stamping after follow-up triage. They therefore agreed with Care UK that they would change their time-stamping process so that the time of clinical assessment was recorded after the initial assessment but they would not change any navigation or triage processes.

6.115 UCC managers explained that the clinical assessment time was now recorded when the navigator checked the patient's details in ADAstra and added them to the treatment queue. The UCC data we saw included the initial clinical assessment (i.e. navigation) and treatment time but not the follow-up triage time.

6.116 The general manager told the CCG at the contract management meeting on March 2015 that:

“... the change in measurement was implemented in the final week of January, and the January figures reflect that it had an immediate effect on performance.”

6.117 He added that the February data, which is not yet validated, indicates performance of 96 per cent on adult assessment and 92 per cent on children. He confirmed that the patient journey is the same as it was before but is just being recorded differently, so there are no issues with clinical safety.

6.118 The acting managing director of Ealing CCG said:

“It is ... to do with when they are time-stamping. It isn't to do with a change in practice..”

6.119 The deputy service manager told us that staff had not initially understood the change:

“We spent a lot of time with our staff saying, clinically nothing is changing, we are just changing where the clock should be accurately measuring. So we had the same backlash internally as well.”

6.120 She said this was why staff raised their concerns about misreporting the clinical assessment KPI with the reporter in the ITV Exposure programme.

6.121 Most staff we spoke to now understood the change. However, the lead nurse was under the impression that the role of the navigator was simply to direct the person to ED or UCC and that they would need to see another person for triage within 15 minutes for a child and within 20 minutes for an adult.

6.122 The report of the CCG clinical visit to the UCC on 6 July 2015 says:

“Clinical staff were very clear that they act primarily on the clinical needs of their patients. Whilst cognisant of the importance of performance indicators staff felt they were not influenced by these at the expense of making safe and appropriate clinical decisions.”

6.123 The CCG has not imposed financial sanctions for underperforming on KPIs for the last two years of the contract. We discuss this further in section 7.

Comment

The UCC changed its process for time-stamping the clinical assessment in January 2015. The clinical process of a quick clinical assessment, followed by a later follow-up triage, did not change. The change in time-stamping came about as a result of discussions with the CCG, who had researched standard practice across North West London. There is no financial incentive for Care UK to manipulate the KPIs as the CCG have not imposed any sanctions for underperformance since year one of the contract. The allegation that the clinical assessment KPI was being manipulated is unfounded.

Clearly, staff had concerns about the change in process and there is still some confusion about when the clinical assessment is time-stamped.

The change in time-stamping from after clinical assessment/triage to after navigation means that it is not possible to know whether all urgent patients are seen for follow-up clinical assessment within 15 minutes and all other patients within one hour as per the national guidance because this is not being measured.

The UCC contract sets out navigation and clinical assessment separately but navigation at the UCC reception seems to fulfil both clauses. The navigation is a hybrid of a quick assessment and a definitive triage. Navigation asks more questions than a quick assessment but fewer than a proper triage would. A thorough quick assessment would help with the loss of privacy and dignity that results from carrying out an assessment at the reception. We discuss the issue of privacy and dignity in a later subsection.

We discuss in the next sub-section whether the system of assessment is adequate.

The allegation: the system for assessing patients on arrival at Ealing UCC is inadequate

6.124 A second undercover reporter filmed her interaction with reception when she presented with malaria symptoms. The navigator asked the reporter to take her own temperature.

National policy

6.125 Some of the national policy we set out in the sub-section about contractual KPIs being manipulated at the UCC is also relevant to this section.

6.126 The *Triage position statement* jointly published in 2011 by the College of Emergency Medicine (CEM), Emergency Nurse Consultant Association (ENCA), the Faculty of Emergency

Nurses (FEN) and the Royal College of Nursing (RCN) sets out in detail the various elements of good triage practice. It explains that triage:

“... may take the form of a few specific questions selected to rule in or out serious conditions, or include a full initial clinical assessment ... The result is the assignation of a priority to the patient thus helping manage workload and ensure the sickest patients are seen first.”

“the initial clinical assessment ... may be a part of triage or may occur subsequently. This requires not only the vital signs to be measured but also includes a brief history and immediate plan of care. This process allows the clinician to start any immediate treatment needed and to order relevant investigations prior to the definitive clinician assessment allowing a faster and more efficient pathway for the patient.”

6.127 It also recommends that:

“individual departments should have an agreed and documented triage training process for staff which is auditable” and “The triage process should be robust, reproducible, clearly documented and auditable. Triage audit should include time to triage and pain assessment. In addition, triage audit should support national standards, e.g. pain assessment and identification of time- dependant clinical conditions such as cardiac chest pain, stroke thrombolysis and early antibiotic therapy in sepsis.”

6.128 The Royal College of Emergency medicine sets out triage principles and standardised guidelines for quickly assessing particular conditions.

6.129 The Manchester Triage System (MTS) is a nationally recognised clinical risk management tool used by emergency department clinicians to safely manage patient flow when clinical need exceeds capacity. The guidance aims to ensure consistency and safety of patients during triage. It also sets out guidelines for quickly assessing and categorising certain conditions/situations, such as an unwell child.

6.130 NICE Quality statement QS 64 (2014) for acutely ill feverish child under 5 states:

“Infants and children under 5 years who are seen in person by a healthcare professional have their temperature, heart rate, respiratory rate and capillary refill time measured and recorded if fever is suspected.”

Local policy

6.131 Some of the local policy we set out under the sub-section about contractual KPIs being manipulated at the UCC is also relevant to this section.

6.132 The *Brent and Ealing urgent care services navigation policy* (2013) describes navigation:

“Navigation is undertaken by general medical and nursing practitioners. It is defined as the rapid assessment of a patient. It encompasses a focused, but brief history, examination and when relevant recording of vital signs. This process should not take no [sic] longer than a few minutes to undertake when performed by an appropriately qualified member of the clinical team.

No patient should wait > 20 minutes from walking into the centre to be assessed by the Navigating clinician (>15mins for Children).”

6.133 The navigation policy is a guide to decision-making for the navigating clinician and sets out explicit inclusion and exclusion criteria for both adults and children. The following are examples of “automatic exclusion criteria”:

- *“Patient presenting within 30 days of discharge from Brent or Ealing hospitals with the same problem e.g. post operation infections.*
- *Patient repeat attending within 72 hours with same presenting complaint and seen by ED or hospital specialty*
- *Patients who are likely to need treatment in the ED or inpatient specialties*

- *Patients with life or limb threatening injuries*".

6.134 However, it emphasises that the document is not prescriptive and experienced GPs should "*exercise good clinical judgement in the application of this guidance*" and "*Nurse Practitioners should follow established protocols when applying this guidance*".

6.135 The document says it is supported by workshop training and regular clinical performance review.

6.136 The policy does not include guidelines for the quick assessment of specific conditions.

6.137 The UCC has a 'triage red flag' document that lists presenting symptoms associated with eight potentially serious clinical conditions including venous thromboembolism, nose bleed, stroke , chest pain and vaginal bleeding.

6.138 There are no policy or guidelines associated with the follow-up triage.

What happens in practice

Navigation

6.139 Staff told us that the navigator was also the shift lead and they used the navigation policy inclusion and exclusion criteria to aid their navigation decisions. A nurse told us that she used the MTS when navigating. She had been trained in it in a previous ED post.

6.140 Our nurse clinical adviser observed a navigator asking patients questions to determine where they should be navigated to and how urgent their needs were. One patient, a woman who was 25 weeks pregnant, came to the UCC reception complaining of back and right-side abdominal pain. The navigator asked her to sit and complete her registration form, which took 10 minutes and she was not triaged for another 25 minutes.

6.141 We did not observe any patients being asked to take their own temperature or any other diagnostic tests taking place at reception during navigation. The service manager confirmed this had never been the process at the UCC and the nurse navigating was acting outside normal processes. Care UK confirmed that this *“has been addressed with the individual”*. Care UK also confirmed that the navigating clinician may take the pulse or oxygen saturations of a patient using a portable monitor but they would not be asked to do this themselves.

6.142 The service manager told us that all the nurses work as the navigator and some are better at the role than others.

“Where they may be 70 per cent confident at the front desk, they aren’t brilliant at doing treatment - it’s a real balance. Not everyone is the same ... but we are aware of that, and we are still going to encourage. There is lots of learning going on all the time and what we don’t want to do is have a brilliant shift lead at the front desk all the time, and some of them are brilliant, because it wouldn’t be fair on them...”

6.143 Both UCC and ED interviewees told us patients were sometimes navigated to the ED but the ED consultants disagreed with the navigation decision. An ED manager and consultant thought that this was because patients had been inappropriately navigated.

6.144 The lead ED clinician told us she was concerned about the quality of navigation in the UCC. She told us that UCC navigators might be inexperienced and lacking competence to perform the navigation role. She believed that the navigator should be a senior nurse with specific “streamer competencies”.

6.145 She told us she had sat with the navigator at the UCC on 15 September 2015 and made a number of recommendations at a joint ED - UCC meeting a few days later. Recommendations included:

- Patients should be booked in and their details entered directly onto Adatastra when they arrive at the UCC by receptionists.

- Navigation should take place after registration and navigation decisions documented live onto Adastra. Navigator should use more clinical questions to allow accurate “signposting”.
- There should be a drug cupboard available during navigation - with water and cups for patients to receive analgesia.
- Patients should be sent to x-ray from navigation if appropriate.
- There should be a patient ‘administrator’ who can find GPs, make GP appointments and educate patients about the role of 111, UCC and the ED.

6.146 The Care UK UCC serious incident log records an incident on 29 September 2015. A 27-year-old patient attended the UCC with symptoms of a *“possible stroke”* and was navigated by the shift lead to the UCC. Another patient of *“similar age”* and *“slightly similar presentation”* also attended the UCC. The first patient was prioritised inappropriately as not urgent and the second as urgent. The first patient waited 50 minutes for full assessment at which point *“the priority was recognised and appropriate action taken”*. The shift lead explained that she had recognised the first patient as needing urgent follow-up triage but there had been *“a mix up over patient identity”*.

6.147 This incident is discussed again in section 8.

6.148 The CCG requested in a September 2014 contract review meeting that the UCC look into how best to record redirected patients to ensure their visit in the UCC was captured. The general manager told the CCG in a contract review meeting in January 2015 that a manual log of redirected patients (other than those sent to the ED) had been developed and figures would be included in the performance reports. Our clinical advisers observed patients being redirected and asked the navigator how these patients were recorded. We were told that they did not log this information. The service manager confirmed that this log was not routinely used. In response to our draft report Care UK told us that all patients are added to Adastra. The new registration and navigation process introduced in October 2015 stipulates that this information is logged.

6.149 Monthly performance reports submitted to the CCG record the *“number of patients navigated out of the department (i.e. signposted elsewhere)”*. A comment next to the

number says “Assumed Attend Disposal 11-15”. The service manager explained that this number related to patients who had been registered and seen in the UCC who were discharged and directed elsewhere, for example to the pharmacist or the dentist. The data was taken directly from AdastrA.

6.150 The acting managing director of the CCG explained that the UCC blanket exclusion of all patients who present to the UCC within 30 days of discharge from Ealing hospital with the same or related problem was so that re-attendance rates to the hospital could be measured. She explained that these rates can indicate whether care was properly completed.

6.151 The lead GP was keen to emphasise that although the policy sets out a blanket exclusion of patients who re-attend, he would expect the navigating clinician to treat each patient on a “case by case basis”.

Comment

The UCC have a navigation policy and exclusion criteria but these do not include standardised guidelines for quickly assessing particular conditions such as those in the RCEM protocols. There is some evidence to suggest that some patients are inappropriately navigated to ED and we were told that navigators’ ability varied. It is therefore all the more important that the UCC sets specific guidelines for navigation, that competencies for navigators are set out clearly and monitored by the lead nurse.

The UCC service manager told us that the incident in which a patient was asked to take their own temperature was a departure from normal practice. It is not described in any policy we saw but we have no evidence of how widespread the practice may have been at the time of the programme. However on balance we think that today patients in the UCC are not asked to perform their own diagnostic tests during navigation.

The old system of registration and navigation did not require navigators to produce a full written record of all navigation discussions and the navigator had to remember

the details to input onto Adastra later. This could be a lot later, especially when the department was busy. This system was one of the root causes of the serious incident in which a stroke patient waited too long in the UCC because the navigator confused two patients and thus incorrectly assigned a priority of non-urgent. The new system of registration and navigation should help prevent a recurrence.

If the UCC does not make a record of patients navigated to the ED or away from both the UCC and ED, this means that the performance metric for patients being navigated out of the department is not accurate.

The automatic exclusion policy for re-attenders may not be in the patient's best interests. It would be preferable for the patient if they were always assessed according to their clinical need. The policy also means that the ED may be congested with patients who would be better treated in the UCC. For example, a patient with a minor post-operative infection who needs a dressing changed. The CCG explained that this happens in order to measure and record hospital statistics - infection rates etc. We argue, however, that the UCC could collect data to submit to hospital about such patients. This is discussed further in section 8.

Recommendation

R9 The UCC should record all navigation discussions and decisions. The record should be given to the emergency department for patients transferred there and retained for patients navigated elsewhere. The UCC should regularly report numbers of patients navigated away from the UCC to the CCG.

Follow-up triage

6.152 We spoke to three nurses who conduct follow-up triage and they told us that their role included taking a history, observations, ordering any necessary tests and categorising a

patient as urgent or non-urgent. They also decide whether it is safe for the patient to wait in the waiting area.

6.153 We asked one nurse whether she followed any clinical protocols during triage for specific illnesses and injuries. She told us the UCC had some set clinical pathways for “various conditions” and “red flag” symptoms. We asked UCC managers for the guidelines for treating specific illnesses and injuries and pain relief standards that the nurses follow during triage and were provided with the navigation policy, triage red flag document, documents setting out the front desk and psychiatric pathways and guidance on fracture management and x-rays.

6.154 One GP told us:

“I can remember when I have seen patients where something should have happened that hadn’t happened (i.e. obs). I don’t think I have ever seen anybody that is really, really sick (that was not triaged as urgent when they should have been) ... sometimes what happens is you get to see the patient and actually what you are seeing them for does not bear any resemblance to what has been written down in the triage. Due to us being such a diverse area, that can be because of communication difficulties”

6.155 The lead GP explained that he identified any patients who he treated who had been inappropriately assessed/triaged and discussed them with the assessing ENP or the lead nurse. He told us that they “*had to take certain nurses off shift because they’ve made some decisions that we deemed were not appropriate, and that does happen.*”

Comment

Although the UCC has some navigation and triage policies and pathways we found no evidence of a standardised triage system and no protocols for assessing specific conditions nor pain relief standards for staff to follow. The competency of those performing triage was variable.

We conclude that there are some elements of the assessment process that could be improved and therefore partially support the Hardcash allegation that the system of assessing patients on arrival at the Ealing UCC is inadequate.

Training and audit

6.156 UCC clinicians are not expected to attend specific navigation or triage training.

6.157 UCC managers told us that other than paediatric observations they do not audit the navigation and triage process.

6.158 The lead GP told us that UCC managers analysed all late referrals to the ED to see if the patient was inappropriately triaged to UCC or should have been marked as urgent but was not. He told us that ED staff often logged an incident on Datix when a patient had been inappropriately navigated to the ED or sent to ED too late. The lead GPs would then do root cause analysis for all of those cases. We saw a sample of these cases.

6.159 A baby died on 14 August 2013 after care in the UCC and ED. A Serious Incident (SI) report was produced on 21 October 2013 and a coroner's inquest was held on 10 September 2014.

6.160 In a letter to the coroner dated 24 September 2014, solicitors for Care UK respond to the coroner's request for information about what actions have been taken since the incident. The letter states that the coroner had accepted the oral evidence at the inquest of the UCC doctor that nursing staff were now carrying out routine observations on all patients. The coroner had requested clarification about the auditing process to ensure compliance. The letter explains that UCC clinicians had been reminded that they should perform observations if nurses had not performed them already and that an audit of paediatric observations was being undertaken and should be complete by Friday 26 September 2014. The lead audit GP told us that as a result of this they started to audit the observations conducted during child consultations (including assessments and treatment

sessions). The audits started in September 2014 and took place every three months until May 2015. The audits reviewed 30 case notes for children under 16, selected at random over a varying period of time (between one and three months).

6.161 The audit report dated 25 September 2014 says the audit checked the following paediatric observations: pulse, respiratory rate, capillary refill time, temperature and oxygen saturations. It found that 71 per cent of cases (where observations were indicated) had observations recorded during assessment (within 45 minutes of arrival) and 21 per cent had observations during treatment, eight per cent had no observations recorded. Performance at recording certain observations were worse than others:

“The most frequently neglected observations included both respiratory rate and capillary refill time. These were performed in only 11 cases (46 per cent) and 9 cases (37 per cent) respectively of the indicated cases.”

6.162 The audit report recommended methods for improving performance, including emphasising to clinicians the importance of observations through clinical meetings and group email, continuing to monitor assessment breaches to check adherence to the new protocol and providing individual feedback to clinician who underperform.

6.163 The audit was discussed in the contract review meeting in November 2014 and the lead audit GP explained that a new process for paediatric observations had been put in place in the UCC because of the poor performance. Under Fives have the five key observations taken at the initial assessment and those between five and 16 have three key observations. These would be re-audited in January.

6.164 An A4 laminate document displayed in consultation rooms sets out the five observations to be recorded in children of five years or under. We saw no equivalent document for children aged five to 16.

6.165 In the audit dated 6 January 2015, 52 per cent of 30 cases reviewed had observations recorded during assessment and 40 per cent during treatment. Only one case had no observations recorded. Eighty-one per cent of patients had three or more observations

recorded.

6.166 Separately, the audit report explained that 13 of the 30 children reviewed were under five and the auditor checked whether all five paediatric observations had taken place.

6.167 Actions were the same as the last audit but this time included the lead nurse to provide training to nursing staff.

6.168 In the contract review meeting in March 2015 the lead audit GP explained that *“five observations should be taken from all paediatric patients”*. He said the *“ambition is to reach 80 per cent on these audits”*. The lead GP explained that the UCC had had good feedback from a paediatric consultant on its processes for treating children.

6.169 In the audit of 6 May 2015, 68 per cent of patients had observations during assessment, all others had observations during treatment. The audit highlights the cases where observations were not taken during assessment as an issue:

“6 of 19 cases still did not have any observations recorded within 45 minutes of arrival. This is likely due to a combination of the volumes arriving in the department and pressure on nursing staff to complete assessments efficiently. This has been discussed with the wider management team and assessing staff will be audited on the quality of their assessments by the lead nurse. Any necessary training needs can be identified and provided.”

6.170 For under-fives the performance against the five observations for January and May 2015 is compared:

Observation	Percentage recorded (Jan 15) - 13 cases	Percentage recorded (May 15) -8 cases
RR	46%	75%
CRT	46%	88%
Pulse	69%	75%

SATs	69%	50%
Temp	85%	100%

6.171 The lead audit GP told us that performance had significantly improved with time. He thought that change in practice had been bought about by educating clinicians about the importance of certain observations for indicating certain conditions and by putting a laminate in every clinical room setting out the observations needed for all under-fives.

6.172 As a result of the improvement, he had decided to reduce the frequency of the audit to every six months.

Comment

Clinicians do not receive specific training in navigation and triage, and their work (other than an audit of paediatric observations) is not audited. The lead GPs analyse and investigate inappropriate navigation and late referrals to the ED - which allows them to identify some clinicians who are not performing well. This process is not systematic enough to assess whether all clinicians performing triage are appropriately assessing patients. This information is vital for assessing individual clinical performance.

Given the issues highlighted in the allegation and described above, the UCC should set specific guidelines for both navigation and triage and combine the guidance with training and audit to check compliance against the guidance.

Audits of paediatric observations were introduced as a result of a specific request from a coroner after the inquest into the death of a baby treated by the unit in August 2013. The audits of paediatric observations do not follow the sampling methodology recommended by the RCGP/ICEM Urgent and Emergency care clinical audit tool kit. Numbers are too small, particularly for children aged five years and under, to give an accurate picture of what is happening in practice. The audit reports provide no

explanation for why only three observations are performed in some of the cases, nor evidence as to which three are performed. It is good practice for all paediatric patients, regardless of age, to have five observations performed unless they present with something very minor for example a bruised toe. In addition, we think the audits showed that paediatric patients were waiting too long to have observations (the shortest time category referred to in the audit as 'within 45 minutes'). It is important to recognise sick children as quickly as possible when they present at the UCC.

Although the audits show improvements in the documentation of paediatric observations, actions to improve audit performance have not brought it to an acceptable level and we think the frequency should remain at three months not be reduced to six.

The coroner expressed concern about the lack of documentation of observations at an inquest and we think the UCC practice and audits have not yet adequately responded to that concern.

Recommendation

R10 The CCG should ensure that as part of the new UCC contract UCC managers:

- develop detailed navigation and triage guidance and clear protocols for assessing specific conditions and symptoms based on national guidance and best practice;
- ensure that staff undergo training to ensure they understand the guidance; and
- regularly audit to ensure that the guidance is complied with.

The allegation: patient's privacy and dignity is compromised when being assessed at the UCC reception

National policy

6.173 CQC Regulation 10: Dignity and respect, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10

“providers must make sure that they provide care and treatment in a way that ensures people's dignity and treats them with respect at all times. This includes making sure that people have privacy when they need and want it...”

6.174 The CEM, ENCA, FEN, RCN *Triage Position Statement* (2011) describes how the triage environment should be set up:

“The triage environment should be conducive to the exchange of confidential information...”

6.175 *Standards for children and young people in emergency care settings* (2013) states:

“Young people should not be asked any potentially sensitive questions where they may be overheard for example in the reception, waiting areas, ward environment; a child's privacy and dignity must be maintained through their care pathway.”

Local policy

6.176 The UCC contract says: *“the provider shall ensure that the provision of the services and the Unscheduled Care Centre Premises protect and preserve patient dignity, privacy and confidentiality”*.

6.177 The Care UK *Privacy, dignity and respect policy* (2013) lists a number of “dignity tests” related to the “right to privacy”:

- *“Care UK has quiet areas or rooms that are available and easily accessible to provide privacy;*
- *Staff actively promote individual confidentiality, privacy and protection of modesty;*
- *The right to privacy includes non-physical privacy such as the right to ensure person correspondence is kept private.”*

What happens in practice

6.178 The general manager told us that the UCC and ED areas were redesigned to be co-located in November 2012. The joint UCC and ED reception area was created at this time. Care UK told us that they, the PCT and the trust were all involved in this re-design which was limited by the space available in the UCC.

6.179 All ambulatory patients attending the UCC are directed to a reception desk located behind a glass panel. Navigation takes place at reception. Until October 2015 the navigator sat at reception behind a glass screen. The patient was able to speak into a microphone but we noticed that both the patient and navigator had trouble hearing one another.

6.180 Our clinical advisor observed a patient who presented to the navigator with vaginal bleeding and back pain. The navigator asked her at reception how many pads she had used since the night before. The patient appeared to be embarrassed because she could be overheard. She waited 25 minutes for a follow-up triage.

6.181 The lead GP asked patients at two forums in April 2015 whether they felt comfortable speaking to the receptionist behind the glass. Patients at one forum said yes but that they preferred to speak privately about any personal matters. One patient did not feel listened to at the reception desk. Patients at the other forum said they felt comfortable speaking to receptionist because they were in hospital.

6.182 Four out of 20 patients surveyed by Healthwatch Ealing did not feel they were treated in a private and confidential environment.

6.183 The general manager told us that the UCC provided a separate room if patients asked to be seen privately.

6.184 Root cause analysis (RCA) of late referrals attached to the Joint Service Review report¹ for April to June 2014 shows that patients do not always give the correct details at navigation about what is wrong with them.

6.185 All UCC staff we spoke to told us they thought the patient's privacy and dignity could be improved.

6.186 The lead nurse told us he sometimes found when he treated a patient that their story differed from the one they gave the navigator because they did not want to give some details at the front desk. He told us he was not lead nurse when the reception area was redesigned and that he and the other nurses had raised concerns with the lead nurse about the privacy and dignity of patients at reception. He did not know whether the concerns had been discussed with the CCG. He had also raised the issue with the general manager and, since becoming lead nurse, with the CCG at contract review meetings.

6.187 The UCC log records a complaint in October 2014 in which a patient raises confidentiality issues at reception. The log describes part of the response: *"issues with confidentiality at the reception desk are currently being discussed with commissioners"*

6.188 We found no reference to this matter in the contract review meeting minutes.

6.189 The lead audit GP talked about the problem:

¹ Joint service review reports are produced quarterly by the UCC

“I think it is a problem, personally. I wouldn’t share my innermost problems at that front window if I was a patient. It is something that has been raised with the CCG again, even before my time...”

6.190 The acting assistant director of unplanned care at the CCG who is responsible for the UCC contract and who attends the contract review meetings, said that neither UCC managers nor patients (via concerns or complaints) had raised the issue of privacy and dignity.

6.191 The lead nurse said conducting navigation in a private booth without glass would be an improvement.

6.192 The service manager told us that she had suggested that the glass be removed but that this was not possible for safety reasons. She thought that a phone booth with a hole in the glass through which the conversation could take place would solve the problem.

6.193 Navigation has taken place since October 2015 at a hatch at the side of the main reception, which has small side panels and has a window that can open. The hatch is opposite and close to the paediatric waiting area. The navigator may conduct diagnostic tests such as taking a patient’s temperature or blood pressure at this window. A sign explains that patients can request greater privacy for the initial triage.

Comment

We support the Hardcash allegation: information discussed with the navigator at reception is sometimes sensitive and a patient’s privacy and dignity are compromised. However we recognise that this is not an unusual situation for reception facilities in UCC and ED settings. We have found some evidence to suggest that the lack of privacy means that patients do not disclose the details of their condition accurately and in full to the navigator, perhaps because of a lack of privacy.

UCC staff say they raised this with managers and with the CCG but the CCG does not recollect this issue having been raised, nor is it recorded in the minutes.

The more private booth to the side of the reception has improved privacy during navigation but is close to the paediatric area and is not private enough for sensitive conversations. Redesigning reception so that the navigation station is not so close to or directly opposite the paediatric areas would benefit patients.

We make a recommendation about redesign of the UCC in section 10.

The allegation: general failings in nursing and inappropriate waiting times for patients with potentially serious conditions (due to inadequate assessment)

6.194 The lead audit GP was filmed saying that the lead nurse is under a lot of pressure because he has to manage the nurses alone, whereas there are two lead GPs. He alleges that the standard of nursing is not high and there are always problems that the lead nurse has to deal with.

6.195 He goes on to say that this results in problems with the assessment process so that a patient with potentially life-threatening problems could wait three hours to see a GP. He specifically refers to an ectopic pregnancy.

National policy

6.196 RCN guidance *Accountability and delegation: a guide for the nursing team* (2015) makes clear that the registered nurses are responsible for ensuring that health care assistants (HCAs) must be asked to perform only tasks that fall within their assessed competence.

6.197 The Department of Health guidance *National quality requirements in the delivery of out-of-hours services* (2006) about audit of patient contacts (set out under subsection about GPs earlier in the section) also relates to nurses.

6.198 Various nationally recognised methods categorise patients who access emergency services including Manchester Triage System which categorises patients into five levels including: immediate resuscitation, very urgent, urgent, standard and non-urgent.

6.199 The College of Emergency Medicine *True triage* sets out five levels and the time within which type of patient should be seen.

6.200 The NHS England guidance *Safer, faster, better: good practice in delivering urgent and emergency care* (2015):

“UCCs must aim to manage most of their patients within two hours of presentation. Triage is generally inappropriate in UCCs - best practice is to use a ‘see and treat’¹ approach, with protocols to ensure that those waiting for treatment are fast tracked where necessary.”

Local policy

6.201 The local policy referred to in the UCC contract and staff competencies set out in the subsection about GPs earlier in the section also applies to this subsection.

6.202 The UCC contract states that clinical staff should have the competencies to recognise ‘red flag’ symptoms in pregnant women that require emergency hospital admission, including ectopic pregnancies. It says clinicians should be aware of atypical clinical

¹ See and Treat is a process whereby a senior clinician sees patients with minor conditions soon after they arrive at an ED or UCC. Such patients are given their definitive treatment straightaway and can then be discharged.

presentations of ectopic pregnancy and especially of the way it may mimic gastrointestinal disease. Fainting in early pregnancy may indicate an ectopic pregnancy.

6.203 There is a job description for the lead nurse setting out clinical and managerial responsibilities including (but not limited to):

- *“Support junior staff with supervision and development.”*
- *“Take a personal responsibility to maintain own **and other nursing staff** NMC registration and professional development in line with the expectations of the role.”*
- *“Maintain competencies associated with the role ensuring you are working within your own limitations / scope of practice.”*
- *“To participate and assist in the systematic monitoring, review and evaluation of nursing practice through clinical audit. Providing feedback results to line managers and staff to improve patient care in the unit.”*
- *“Ensure updated mandatory training requirements are met and equipment training records are maintained.”*

6.204 There is no job description for nurses who are not yet qualified as ENPs.

6.205 The UCC has an advanced nurse practitioner (ANP) and an emergency nurse practitioner (ENP) job description. Both job descriptions are the same. Specific responsibilities include:

- *“Administer treatment within local guidelines / protocols.*
- *To maintain competencies associated with the role ensuring you are working within your own limitations / scope of practice.*
- *Administer medication within Patient Group Directions or if qualified and appropriate to the centre via Independent Nurse Prescribing.*
- *Develop / maintain advanced clinical skills. i.e. x-ray interpretation, suturing, plastering, nurse led services.”*

- *“To participate and assist in the systematic monitoring, review and evaluation of nursing practice through clinical audit. Providing feedback results to line managers and staff to improve patient care in the unit.”*

6.206 The *Advanced nurse practitioner induction procedure* (2014) sets out the selection criteria and process and the induction process. Induction consists of one shift in which the new ANP observes a supervising ANP, one working shift accompanied by a supervising ANP after which competent ANPs are signed off and an optional third sign off shift if not all competencies were met in the second shift.

6.207 The pack sets out a competency framework and a timetable in which competencies should be checked:

- *“After the first independent shift (mandatory)*
- *After 4 weeks (mandatory)*
- *At 8 and 12 weeks (at the discretion of the medical/nurse lead)*
- *Then every 6 months in line with PDP/appraisal guidance to ensure continual competence and development.”*

6.208 It explains that reviews *“involve an audit of a minimum of 10 cases plus an interview to identify issues and establish next steps as needed.”*

6.209 The competency framework sets out the level of competency for specific tasks the nurses are expected to engage in, including knowing how to assess, diagnose, manage and show awareness of *“red flags and safety netting”* for specific conditions.

6.210 The HCA job description states that an HCA responsibility is *“suturing and plastering under clinical guidance.”*

6.211 The Navigation policy (2013) says:

- *“All staff in conjunction with the navigating clinician are responsible for maintaining oversight of the waiting room and being responsive to cues suggesting patients may be deteriorating.*
- *They should alert the navigator, who must be open to the concept of re-triaging a patient in light of an acute change in their condition.*
- *All staff must be familiar with how to summon help if a pt collapses in the waiting area and be able to assist with initial resuscitation efforts.”*

6.212 The navigation policy excludes:

- pregnant patients with persistent vomiting;
- PV bleeding (heavy)...; and
- pregnancy with abdominal trauma.

6.213 The UCC does not have any protocols or referral pathways related to pregnancy related illness for patients navigated to the UCC.

6.214 The GP induction pack explains: *“It is also important that you see patients in time order and not to ‘cherry pick’ cases - patients may be waiting for several hours and will become understandably upset if they feel they are waiting longer than others to be seen. The only exception to this is if you are asked by the shift lead or navigator to promptly see a specific patient who has been identified as an ‘urgent’.”*

What happens in practice

Nurse and HCA induction, competencies and training

6.215 The lead nurse told us he had been in post for eight months, after having worked as an emergency nurse practitioner (ENP). He had two non-clinical days and three clinical days per week. In his non-clinical time he managed the nurses and HCAs, prepared their rotas, attended the biweekly teaching sessions, ordered drugs and was involved in safeguarding processes and standards along with the safeguarding lead.

6.216 He told us that on his non-clinical days he is often expected to work clinically when the department is busy and does not have enough time to perform all his non-clinical duties.

6.217 He said he was asked to take on clinical duties on his non-clinical days *“very often”* for *“an hour or two on average”*.

6.218 The lead nurse told our clinical adviser during the time she observed the UCC that he had spoken to managers about this.

6.219 He told us he was line-managed by the general manager and by the Care UK director of nursing. His competencies were checked when he was working as an ENP but his competencies for the lead nurse role had not been set or checked since he took on the role.

6.220 Care UK told us that the lead nurse had not raised any concerns with the director of nursing about his ability to perform the role.

6.221 The log of experiences and competencies (undated) shows four ENPs and two nurses work in the UCC.

6.222 The rota model has 10 nurses working each day, including agency nurses.

6.223 The training log shows three substantively employed nurse practitioners (one of whom has since left), including the lead nurse and five self-employed nurse practitioners who work in the UCC.

Clinician	ALS / ILS	APLS / EPLS / PLS / PILS	Red Dot Radiology Course	Prompt Course	Safeguarding Children Level 3 (Face to Face)	UCC Skills workshop	BLS
NP1						2015	2015
NP2	2013	2014	2014	2014	2014	2015	2015
NP3					2015	2015	2015
NP4	2015	2014	2014	2015	2014		2015

NP5	2015	2013	2013	2015	2014		2015
NP6	2015	2012	2012	2014	2014		2015
NP7	2015	2014	2014	2014	2014		2015
NP8	2015	Never	?	?	2015		2015

6.224 The statutory and mandatory training for substantive nurses is RAG rated as green in October 2015.

6.225 The nurse induction is two weeks. The lead nurse explains UCC policies, online training and how to keep up to date. The induction involves observing the lead nurse, ENPs and GPs during triage and consultations.

6.226 One nurse told us the induction process had been helpful.

6.227 The lead nurse said he was responsible for checking and monitoring nurse competencies. However, since the last lead nurse left he had not been able to find the relevant file. He was in the process of checking competencies again for the UCC nurses.

6.228 Nurse patient consultations are audited. Care UK told us that *“there is a plan going forward that nurses will be included within the audit schedule”*.

6.229 A nurse told us that she had worked in the unit for a year and had still not had an appraisal, which she believed should be carried out every six months by the lead nurse. She said she had to set her own targets, which she had met.

6.230 Some nurses in the UCC were training to become ENPs. In order to do so, a nurse must complete a number of courses:

- a GP-plus advanced nurse practitioner eight week course;
- x-ray course;
- a minor injuries course; and
- a minor illnesses course.

6.231 Each nurse training to become an ENP has a GP mentor/supervisor who helps him or her establish a portfolio of competencies. In order that these competencies are signed off, the nurse must gain practical experience in the UCC. One nurse told us she was concerned that she was not given time to practice and support her training with experience because the UCC was so busy.

6.232 We talked about the use of agency nurses and the lead nurse explained that all the nurses who worked at the UCC had done so for a number of years. He was confident that they had the right skills and competencies. He would review the CVs and competencies of any new agency nurses and observe them when they started work.

6.233 The director of nursing for primary care told us that Care UK was developing a new nurse interview pack and nurse competencies for each nursing role in primary care based on the RCN nursing competency framework.

6.234 UCC staff told us that HCAs performed plastering and simple suturing as instructed by nurses. Any complicated suturing or suturing of the face was completed by a nurse or doctor. We were told that the lead nurse checked the competency of HCAs to perform specific tasks but we found no record that this had taken place.

6.235 The director of nursing for primary care told us that Care UK were working on a Health Care Assistant Competency Framework based on the Royal College of General Practice Foundation HCA competency framework and including suturing and plastering where HCAs were required to carry out those tasks.

Comment

The line management of the lead nurse since he took on the role has not been adequate: his competencies were not checked and his training record was incomplete.

Care UK told us that the lead nurse had not raised any concerns with the director of nursing about his ability to perform the role.

The induction process appears to be comprehensive. However, the ANP and NP job descriptions are the same and there is no job description for nurses training to be ANPs. We have not tested the assertion that nurses training to be ENPs do not have time to practise competencies, but we expect Care UK will want to test this out with their staff following our review.

The lead nurse told us that he is not given time to carry out his non-clinical responsibilities because he is regularly asked to work clinically when the department is busy. He told our nurse clinical adviser that he had raised this informally with Care UK. Given the Hardcash allegations, we would have expected him to have formally raised it with Care UK.

The training log and competencies logs list different self-employed/agency nurses. We found no definitive list of nurses who work in the UCC or record of their training and competencies. The training for the substantive nurses is patchy.

The lead nurse is responsible for checking and monitoring training and nurse competencies but told us that the nurse competency documentation went missing when the previous lead nurse left. He said he was developing competency paperwork for all nurses.

Appraisals have not been done every six months, which contravenes local policy. Nor are documentation audits for nurses completed in line with national policy.

The system of line management of nurses including appraisal, audit, monitoring competencies and training is not in line with local or national policy.

The result is that the UCC cannot show its nurses have the necessary competencies to carry out their work. We would expect the UCC to keep records that all nurses have training in relation to:

- *triage;*

- *red flags;*
- *assessment and examination (if work as a NP);*
- *minor injuries;*
- *minor ailments;*
- *prescribing; and*
- *x-ray management.*

Recommendations

R11 The UCC general manager should ensure within the next month that the lead nurse's non-clinical time is protected to enable him to carry out clinical leadership responsibilities.

R12 The UCC lead nurse should audit the documentation of one per cent of all patient consultations for all emergency nurse practitioners every three months in accordance with national guidelines. These audits should start within the next two months.

R13 The UCC lead nurse should regularly review and monitor nurse and HCA competencies to ensure they are adequately skilled to work at the UCC and keep accurate records of these reviews and competencies. This should start in the next month.

Inappropriate waiting times

6.236 The ITV Exposure programme showed a nurse describing a situation where a child arrived by ambulance, was not triaged, waited three hours before eventually being picked up by a GP who referred her to ED. The nurse told the reporter that staff had been emailed about the incident.

6.237 Nurses performing navigation and triage send the most urgent patients to ED or, categorise them on Aadastra as urgent if they are suitable for the UCC. Urgent cases appear as red in the treatment queue. The treatment queue is reviewed by the GPs and ENPs when choosing who to see next. UCC staff told us that the urgent queue was sometimes

longer than the non-urgent.

6.238 A GP told us that although on the whole clinicians would see patients in the order they had arrived at the UCC, the list was “*dynamic*” in that he would also use his clinical judgment to check if any patients should be seen sooner and that patients had been appropriately triaged.

6.239 The general manager told the September 2014 contract review meeting that workshops had been set up to tackle breaches. He said GPs and nurses often disagreed about the urgency of patients and so the workshops included interactive scenarios for types of patient/condition that commonly breached. The general manager said these workshops would form part of training programme for new staff and would be a rolling event for all staff because the feedback had been good.

6.240 The service manager told us that patients getting ‘lost’ in the waiting room was a problem before the introduction of a colour code system in February or March 2015 (just before the ITV Exposure programme was filmed). The navigator now highlights in pink the names of patients in the queue who are waiting for follow-up triage.

6.241 The lead ED consultant sat with the navigator in September 2015 and noted that a patient waited one-and-a-half hours to be seen for follow-up triage.

6.242 The lead GP told us that he was concerned that some patients had to wait too long.

“Again, it depends on the competency of the Shift Lead at the front desk. That’s probably been one of the most sensitive roles in the department. If it’s a good nurse and they’ve done an initial face-to-face assessment, it may be that the patient is quite appropriate to wait half an hour, or an hour, before they get seen by a nurse to have their x-ray arranged for their ankle. If it’s a young child that’s come in, he’s got a temperature, that’s different. They need to be flagged up as urgent. We will constantly look at the list as well, as a safety net if you like... where patients aren’t assessed in a timely manner.”

6.243 However, another GP told us he never seen a patient who was very unwell who had not been appropriately triaged as urgent or who had had to wait much longer than they should have.

6.244 The service manager told us that the nurse shift lead was responsible for knowing what was going on in the department at any time.

6.245 The lead nurse told us that the navigator could see the waiting room from their desk and that video cameras covered the whole waiting area. He also thought that GPs and nurses kept an eye on the waiting area, too. He told us the UCC did not have a policy of doing repeat observations after a set time.

6.246 A complaint was described in the September 2014 contract review meeting minutes. A pregnant woman complained because her urgency had been rated routine and she did not attend when called. She was later diagnosed with ectopic pregnancy. The minutes record that the complaint had been resolved and it had been agreed *“that a pregnant patient with one-sided abdominal pain should be seen urgently”*. We saw no written guidance for staff about this.

6.247 A patient at a forum in April 2015 raised a concern that *“geographically the location and the layout in the department is that people can be called but miss their names”*. The lead nurse explained to the patient that if the clinician who called the patient receives no response, they check all the waiting areas. Patients who do not respond are called three times in 15-minute intervals. They are removed from the list if they do not respond.

6.248 Healthwatch Ealing complaint and compliment log January to August 2015 records two compliments that although the UCC was being extremely busy staff had worked hard so that patients could be seen as soon as possible. One compliment described the shift lead as trying to call in more staff and as reassuring patients in the waiting room that they would be treated.

6.249 The service manager told us that the ‘see and treat’ model was used at the UCC when the triage nurses had the capacity to treat and discharge.

Comment

The treatment queue is a dynamic list - although GPs and ENPs see patients in the order they arrive and use their clinical knowledge to amend this order as necessary. The most urgent patients are prioritised using a colour-code system. Having just two categories of patient means that sometimes there are more patients in the urgent queue than in the non-urgent queue. Our clinical advisors suggested this problem could be solved by introducing more categories as they had seen working successfully elsewhere.

The lead GP and the clinical lead for ED had concerns about urgent patients waiting too long. These concerns are associated with the competency of some of the navigating clinicians. If the lead GPs have concerns about the quality of navigating and triaging decisions, it is all the more important that triage guidelines are standardised, nurse competencies and training are monitored and triage decisions are audited. Some red flag symptoms for ectopic pregnancy and miscarriage are set out in the navigation policy but it contains insufficient protocols and referral pathways for treating such patients in the UCC. Developing these protocols would help UCC staff spot the signs of ectopic pregnancy before a patient deteriorated in the waiting room. This is also true for other red flag symptoms such as abdominal pain and breathlessness.

Although national guidance recommends that people are seen within two hours in UCCs not four hours (as referenced at 6.191), Care UK assesses, treats and discharges patients in line with national standards. Care UK recognises that at peak times, or for some complex cases the total time in the UCC may be longer. The national four hour target is currently sitting at 95 per cent and the UCC consistently delivers at or below this level.

We support the Hardcash allegation that patients sometimes wait too long in the UCC.

The shift lead monitors the waiting room to provide assurance that patients do not deteriorate. However, the UCC does not have a policy of performing repeat

observations of patients whose observations were found at triage to be abnormal. Such a policy would provide greater reassurance that ill patients do not deteriorate in the waiting room.

Patients are navigated, wait once to be prioritised and then again for a full consultation. This triage duplicates clinical effort and causes delays. Current national policy advocates the use of a 'see and treat' model rather than triage. The service manager told us the UCC followed this but its use did not appear to be widespread and we saw no related policies to support the process. With careful thought, planning and training the 'see and treat' model could be introduced at the UCC - perhaps when the contract is retendered. The model of 'see and treat' is possible only with enough staff to cope with the workload.

Recommendations

R14 UCC managers should develop a policy for performing repeat observations for patients whose observations were found to be abnormal at triage. This should start in the next month.

R15 The UCC and CCG should consider whether a quick clinical assessment at reception followed by a 'see and treat' model would work at the UCC.

The allegation: Ealing UCC is seriously understaffed and staffing levels put patients at risk during busy periods

6.250 The ITV Exposure programme shows the lead audit GP explaining that the UCC is staffed to deal with 160 patients per day but that they may see up to 220, sometimes 230, in a day. He claims that Care UK do not want to pay for more doctors. He goes on to say that it will require something bad to happen to somebody before management will listen.

National policy

6.251 The Department of Health out of hours (OOH) quality requirements (2006) says:

“Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand ... They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.”

6.252 *Safer, faster, better: good practice in delivering urgent and emergency care* - NHS England 2015 says:

“Patterns of urgent and emergency referrals and presentations, while not random, will always exhibit variation hour by hour and day by day (this is ‘normal variation’). When calculating demand, it is therefore essential to take into account normal variation and not to plan around averages. Ignoring variation and planning to meet average demand will inevitably mean the service is under regular stress and queues will develop that may be difficult and expensive to manage.

...

The UECN should create an expectation that prediction and prevention are as important as escalating to meet demand surges.”

6.253 The CEM triage position statement says:

“Some elements of the triage process, such as initial recognition of urgency, may be undertaken by an unregistered health worker, e.g. reception staff using clearly defined “red flags” which identify urgency ... For this reason non-registered health care workers in emergency settings should have basic training in red flag presentations and how to call for immediate assistance.”

Local policy

6.254 The UCC contract says the provider must ensure:

- *“its staffing arrangements as set out in the staffing plan ... are sufficient to mobilise and manage the provision of the Services ... taking into account the Expected Total Number of Attendances and the Expected Number of Attendances ...*
- *it draws on its experience of expected emergency department and unscheduled care work flows to develop a staffing plan which takes into account variation in demand at various times of the day as well as seasonal variation*
- *...*
- *there are, at all times, sufficient numbers of Provider Staff engaged in the provision of the Services with the requisite level of skill and experience to cover Provider Staff absences (for example, holidays and sickness) and to cope with planned or unplanned increases in workload.”*

6.255 The UCC contract sets out the estimated number of patients for the five years of the contract:

Year of contract	Expected Total Number of Attendances at the Unscheduled Care Centre <i>(which relates to those attending the Unscheduled Care Centre either by self presenting or by transfer from the ambulance services)</i>	Capped Number of Completed Episodes <i>(which relates to those treated by the Clinical Unscheduled Care Service)</i>	Cap on Partially Completed Episodes <i>(which relates to those initially treated by the Unscheduled Care Service but subsequently transferred to the Emergency Department)</i>	Required Level <i>(which relates to those transferred to the Emergency Department only)</i> being 90% of the anticipated number of referrals to the
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				Emergency Department
1	99,748	59,847	2,992	35,908
2	94,757	60,879	3,044	30,491
3	89,770	55,892	2,795	30,491
4	84,783	50,904	2,545	30,491
5	79,796	45,917	2,296	30,491

6.256 It also sets out the methods the provider should use to reduce the number of attendances:

- *“establishing systems and processes to facilitate patients to access local primary services e.g. registering patients with a GP;*
- *reducing numbers of frequent attendees/reattendees;*
- *reducing the number of attendees not registered with a GP.”*

6.257 The only provision in the contract that allows Care UK to terminate it arises 56 days after issuing the CCG with a late-payment notice, if payment has still not been made. Otherwise, the CCG and Care UK can terminate the contract by agreement.

6.258 The GP induction pack explains that the UCC becomes busy at times and frequently sees more than 250 patients a day. It explains: *“Although there are no set time slots to see patients, it is expected that a GP will see between 3-4 patients an hour, as an average over the course of the shift.”*

6.259 The Brent and Ealing urgent care centres ‘*SOP: escalation process*’ (2015) sets out what happens if the wait time in the UCC exceeds 90 minutes. It says receptionists should send escalation emails to UCC management or on-call management out of hours every 30 minutes until the wait time is less than 90 minutes. Processes that may be implemented to *“mitigate the reason for escalation”* include *“sourcing staff, extending clinical shifts”*. The policy includes a process for informing the ED about wait times that exceed 90 minutes (we discuss this in section 9).

What happens in practice

6.260 The Care UK response on the ITV Exposure programme to the allegation about understaffing was:

- the UCC is run under a fixed cost contract and it is 20 per cent busier than the CCG envisaged at the outset of the contract;
- Care UK have requested more money to meet winter pressures but the CCG has declined because there is no money available; and
- the UCC has robust and effective escalation to manage peaks in demand.

6.261 The following table sets out the staffing model at the UCC at the time of the allegations:

Role	Headcount current	Rota - model	Vacancy/Variance
NP	5.64	10	4.36
GP	4.48	9.9	5.42
HCA	3	3.5	0.5
Admin	9.59	9.59	0
Management	1.5	1.5	0
Total	24.21	34.49	10.28

6.262 The service manager told us that the staffing model put together when the contract was agreed was based on the UCC seeing much lower numbers of patients than they were seeing now. The general manager told us that the contract anticipated fewer patients year by year but that had not happened. He told us the contract estimated that 50,000 patients would be treated at the UCC in the fourth year (this year) but actually they have seen well over 60,000.

6.263 Our review of data showed that the total number of attendances to the UCC June 2014 to June 2015 was 71,832.

6.264 The managing director of primary care told us that Care UK increased the level of staffing in the UCC 18-24 months into the contract when it became clear that the volumes of patients set out in the contract were not accurate.

6.265 We talked to the service manager about the methods in the contract for reducing attendances. Efforts to reduce re-attenders included discussions with GP surgeries and having an administrator available to make appointments. There was a reluctance by clinicians to take responsibility for turning people away

6.266 Other staff we spoke to referred to how the ethnic and cultural diversity of the Ealing patient population meant that patients did not always understand the GP system and were not registered with a GP. They said UCC staff struggled to communicate and get patients to understand how to register with a GP.

6.267 The lead nurse told us that the managers always ensured that the number of staff working was in line with the rota. However, the number of staff stays the same throughout the week and year and takes no account of predictably busy times (with the exception of bank holidays when they usually call in another person). He thought that there was a mismatch between the numbers of patients arriving and the number of staff on the rota.

6.268 Ten patients of 20 surveyed told Healthwatch Ealing that they thought the UCC was not appropriately staffed.

6.269 Most staff we spoke to told us the UCC was understaffed. However, one UCC GP told us that regardless of the number of patients in the department, he could not remember having seen a patient whose safety had been put at risk.

6.270 The service manager told us she had reviewed the productivity of the UCC clinicians and raised any issues with individual clinicians. She said they were all on board and working hard.

6.271 A number of UCC managers told us that the escalation policy was routinely followed. The lead nurse told us that this happened daily. Our clinical adviser asked to see evidence

of a recent escalation and randomly chose 1 July 2015. The UCC sent us evidence that the first escalation email was sent when the wait was two hours; emails were sent every 30 minutes until the wait time was three hours and number of patients in the department was 36, when they called in more staff to work for five hours. The wait time increased to four hours forty minutes and then began to drop. The service manager explained that the triggers for obtaining extra resource were related to the number of patients in the department, the wait time, how sick patients were and staffing levels. The shift lead made this decision in conjunction with the management team.

6.272 The general manager confirmed that the cost of calling in extra resource was borne by Care UK and had to be justified to his Care UK manager.

6.273 In October 2015 the UCC reported to the CCG more breaches than normal. The reason given was that two GPs were sick and the agency normally used had not been able to provide the extra GPs. The result was that the UCC was understaffed and patients had breached. The CCG told us that the UCC were vetting another agency so that they did not have to rely on a single agency.

6.274 In May 2013 Care UK asked the CCG for more funding to run the UCC because they were operating at a loss. Care UK explained to the CCG that this loss was due to a misjudgement of the demographics of UCC patients and therefore the UCC only seeing 2.8 patients per hour rather than the projected four patients per hour. They had also underestimated GP salaries.

6.275 After a lot of discussion and legal advice, the CCG decided not to give Care UK more funding because the procurement process has been transparent: Care UK would have to deliver the service for the bid price.

6.276 CCG interviewees explained that Care UK told the CCG they wanted to terminate the contract but that after seeking legal advice the CCG advised Care UK that the contract did not allow them to renege on the contract. Care UK's managing director of primary care, told us Care UK offered to do a phased termination but the CCG did not agree to this. The Ealing CCG chair told us that this interaction was discussed at the highest level in both the

CCG and Care UK. She told us that after deliberation Care UK told the CCG that they would continue to *“deliver the contract on the original terms of the contract with no more money”*.

6.277 The managing director of primary care recalled that Care UK agreed to deliver the service as per the contract but would continue to seek additional funding such as the winter funding.

6.278 We have no evidence that Care UK told the CCG that they could not staff the UCC adequately because they were making a loss on the contract. This issue is not mentioned in any CCG contract review meeting over the last two years. The CCG told us that they had therefore not sought any assurance about whether there were adequate levels of staffing in the UCC since the issue of money had been raised.

6.279 The contract management meeting minutes of 4 November 2014 record the UCC service manager explaining to the CCG that extra nurses are called in at busy times but it is difficult to manage if 15-20 patients arrive at one time.

6.280 The lead GP told us that he recommended to both the Care UK local operational team and the CCG that the UCC needed extra staffing at certain times in order to have resilience against predictable influxes of patients. He said he had raised this with the CCG at a contract management meeting in winter 2014/15:

“... asking for more staffing, more resources to be available for Ealing UCC for staff to try and address some of the big spikes in patient activity. Essentially, we were politely refused that resource at the time and we have put in bids previously. I feel that the commissioners are - it’s a case of Care UK signed on the dotted line ‘this is what you’re going to get for it and Care UK need to make the best of what they have’. In reality it’s meant that this department - I’m aware that it loses a lot every year purely to keep the service afloat. That puts tremendous pressures on the department...”

I think the way this service was modelled and what actually has ended up coming through the doors, has been a big mismatch but, then again, Care UK has put in a tremendous resource to try and address the variants there ... They have put in extra GPs.”

6.281 This discussion is not in the minutes. However, the January 2015 CCG quality and safety committee minutes record that “*Care UK reported staffing issues again and UCC staffing challenges being sent back as contract queries.*” No actions are recorded against this statement and the issue does not appear in subsequent minutes.

6.282 The service manager told us that the UCC had made several bids to the CCG for winter resilience funding. They won one bid to help them deal with mental health patients.

6.283 They made six winter pressures bids last year to the CCG and System Resilience Group. They lost five that were to do with patient care, patient flow and reducing re-attenders. They won one bid for an extra paediatric GP in 2015/16.

6.284 We discussed the UCC’s winter pressure bids with the acting managing director of the CCG. She told us that they had not supported the bids because money was finite and better spent elsewhere to help the system manage winter pressure.

6.285 At a contract management meeting in May 2015, the acting managing director of the CCG asked UCC managers if they were aware of the UCC having staff shortages or struggling to get agency cover. The general manager reported no particular issues and said there was generally cover at the busiest times.

6.286 The former Care UK regional manager for London told us that Care UK had recently done an analysis of four years’ worth of patient attendance data against staffing levels and found periods when UCC staffing was less than required to meet demand. This was when the UCC had to escalate. He explained that in some months the UCC was escalating more days than not - “*that is not escalation; that is business.*”

6.287 This data had been presented to the CCG, who had agreed to fund more posts over winter.

Comment

We were told by UCC managers that the staff model is based on the attendances estimated in the contract. Despite vacancies among substantive staff, the UCC met the numbers set out in the staff model by using self-employed and agency staff. The managing director of primary care did not agree with this assessment. She asserted that Care UK increased UCC staffing when it became clear that the actual number of UCC attendances was greater than those set out in the contract. Notwithstanding this difference of opinion we still found that the staff model took no account of predictable peaks in demand, the UCC was often understaffed and in some months the issue was escalated to managers almost daily. We have no evidence that patient safety was compromised because of a staffing problem during the day. However, this regular escalation was not in line with either national policy or the UCC contract. They make clear that the UCC should be able to match staffing to predictable peaks in demand as well as having contingency for when staffing cannot meet demand. The recent incident when the UCC was understaffed because of sickness highlights the lack of resilience in the model.

Methods set out in the contract for reducing numbers of patients have proved challenging for the UCC, either because they were unwilling to send people away because of their duty of care, or because of a lack of staff to help patients register with and make appointments with a GP or because of communication problems and cultural factors.

The UCC contract exposes Care UK to risk by estimating numbers of attendances and capping the episodes of care the CCG have to pay for. A more appropriate UCC contract would include clauses to the effect that the payment structure could be renegotiated if the actual number of attendances differed significantly from the estimate after a year or two of working.

When Care UK requested more funding and to terminate the contract, the CCG should have sought assurances that the fact that the contract was operating at a loss was not adversely affecting the staffing levels and care at the UCC. An analysis of patient attendance data against staffing levels like that recently undertaken by Care UK would have been beneficial at that time.

The staffing issue at the UCC is well known in Care UK but as the contract is running at a loss Care UK have not employed more staff on a regular basis. However, the CCG has agreed to pay for extra staff this winter.

Recommendation

R16 The CCG should ensure that the new contract sets out predicted numbers of attendances based on data from the past contract and that a suitable staffing model is agreed.

Night

6.288 Only two clinicians worked at the UCC at night until September 2015 - one ENP triaging and one GP treating patients. A receptionist worked alone at the front desk. A number of staff told us they thought this level of staffing presented a clinical risk.

6.289 We spoke to a number of receptionists who explained their job at night.

- It falls to the receptionist to monitor the waiting room but this can be hard when they have a lot of other duties, including booking patients in, scanning and booking the fracture clinic.
- If a patient attends with symptoms commonly treated at the UCC (for example a cut finger or a cold), they book the patient into the UCC without consulting a clinician.

- They always call a clinician if they are unsure. The nurse may be treating another patient but comes out of her room to advise the receptionist.
- The ED might help if a patient appears to be an emergency and needs to go directly to the ED.
- There is a navigation policy but it would be useful to have guidelines specifically for the receptionist working at night.
- It can be very busy at night and it can be difficult to take breaks because it leaves reception unmanned.

6.290 The lead GP expressed his concerns:

“Certainly having done nights myself there’s nothing more disheartening than it’s midnight, and there are 30 or 40 odd patients in the department and your colleagues are about to go home and you’re really quite worried. You know it’s going to be a really tough night. It’s not necessarily unsafe, although safety issues can arise from having that volume of patients in the department.

One nurse is suturing, plastering, the GP is seeing another patient ... the receptionist can’t get through, and that’s where my anxiety is and for that reason I made a very strong case to ask for extra resource to have another night clinician there. My feeling is that front desk should be manned 24/7. However, you go to any A&E Department up and down the country, very few departments have a clinician at the front desk.”

6.291 A patient attended the UCC with chest pain on 16 May 2015. The receptionist could not contact the shift lead and registered a patient on the system without their seeing a clinician. The patient was not assessed for 30 minutes. A doctor came into the waiting room, noticed that the patient was very unwell and moved the patient to the ED - where the patient subsequently died. The serious incident log records the following actions:

- *“Competencies and accountability of reception staff needs to be reviewed*
- *Night staffing levels to be re-evaluated in UCC*
- *Night GP and NP need to be available for clinical decision making”*

6.292 The lead administrator sent an email to the receptionists on 22 May 2015, explaining the process for booking in patients in the absence of a clinical navigator. Her email advises receptionists not to make clinical judgements because *“it can have serious consequences for patients”* and lists a number of ‘red flag’ symptoms that should be referred to a clinician before they are booked onto Adastra. She explains that this list is not exhaustive and is not an exclusion criterion; a receptionist who has any concerns or is unsure about a patient should always contact a clinician. If the ENP is busy, they should ask the GP.

6.293 The service manager confirmed that receptionists were not trained to assess life-threatening conditions. However, they have all attended the basic life support course.

6.294 The incident was discussed at the joint Brent and Ealing clinical governance meeting¹ on 3 June 2015 and on 15 July:

“Case has been discussed with A&E, exposed great risk in dept. [Lead audit GP] presents work done on case with extracted patient numbers for June from Harvest. Patients flow from midnight compared to clinicians discharging capacity looked at. Results show only some nights adequately staffed and some nights need additional NP cover from midnight. Proposal of shift for additional NP discussed and rota needs to be overlooked. Analyst brought in to work on this. [The governance manager] suggests proposal for this and work should be presented to [name] new regional medical director for sign off, and to look into terms and budget. [The governance manager] suggested tools used to help front desk receptionist and support.”

6.295 The September 2015 contract review minutes record that the extra ENP at night started in the first week of September and sits on the front desk.

¹ Joint Brent and Ealing clinical governance meetings are held on a monthly basis. Attendees include UCC clinical and managerial leads and the governance manager for the London region.

6.296 We discuss this incident, the classification of incidents and reporting to the CCG in section 8.

Comment

Receptionists work alone at the front desk at night when no clinical navigator is present. The UCC has no guidance setting out the process at night for receptionists to follow and receptionists are not trained to assess life-threatening conditions. This is not in line with national guidance. Receptionists told us that they do not make clinical decisions unless they are sure that a patient is suitable for the UCC. A nurse is called if the receptionist is unsure about a patient. However, this not only delays navigation decisions but also may interrupt treatment of another patient. The receptionists are required to monitor the waiting room but they told us this was difficult because of their competing responsibilities.

The process of navigation and monitoring of the waiting room at night and the level of staffing was a clinical risk until September 2015 when an additional ENP was brought in at night.

After a patient died in the ED, it took three months for Care UK to approve another ENP to work at night. This delay is inadequate. The new ENP should help with some of the problems we describe above but staffing and processes should be monitored to check they meet the needs of patients.

Recommendation

R17 The CCG and Care UK should ensure that the addition of a staff member at night is adequate to provide safe care.

The allegation: there is a shortage of medicines at the UCC

6.297 The ITV programme included filming in the medicine storage room on a Monday, showing sparsely stocked shelves. A member of staff was recorded saying that most of the time it is a bit empty, and that antibiotics go very quickly.

National policy

6.298 NHS Business Authority FP10P-REC forms and their correct usage in Out of Hours (OOH) service provision (2004) states:

“(PCTs) will need to supply two different types of prescription form to Accredited OOH service providers. These are:

- FP10P-REC (Non FP10 Supply Forms) ... designed for a specific purpose - to support the introduction of Out of Hours Centres in February 2005. These OOH Centres provide patients with an opportunity to receive any urgently required medication at the same time and place as the out of hours consultation. The FP10P-REC forms should be used by the OOH provider to record items supplied directly to a patient (i.e. any item not dispensed through a community pharmacy). These forms, should be submitted by the OOH provider ... to the Prescription Pricing Authority (PPA)¹ ... which will enable the PPA to provide monitoring and reporting information ...*
- Standard FP10. Out Of Hours service providers can continue to issue standard FP10 prescription forms, however, if they are to be dispensed by a community pharmacy ... In an OOH scenario, these forms are to be used where there is no immediate treatment required (i.e. where it is not detrimental to the patient to wait until the prescription can be dispensed by a community pharmacy). ”*

¹ The functions of the prescription pricing authority are now carried out by NHS Business Services Authority.

6.299 *Healthcare for London guidance to commissioning PCTs (2010) states:*

“Commissioners and providers should ensure ... that ... where an individual needs to start a course of medicine without delay (for pain relief or because delay would compromise their care), they should receive the full course of the relevant medicine at the same time and at the same place as the consultation ...

... To ensure consistency with urgent care services delivered in polyclinics, urgent care centre patients should pay for their prescriptions where prescription payments are applicable.”

Local policy

6.300 The UCC contract states:

- *“The Provider shall provide to a Patient any drug, medicine or Appliance, not being a Scheduled Drug, where such provision is needed for the immediate treatment of that Patient before a provision can otherwise be obtained; and may provide to a Patient any drug, medicine or Appliance, not being a Scheduled Drug, which a person employed or engaged by the Provider personally administers or applies to that Patient.*
- *The Provider shall have a system in place to ensure that Patients have prompt access to any medicines that they may require ...*
- *Prescribing should either be on an FP10 in hours and out of hours when it is known that a convenient pharmacy is open or by a hospital internal prescription for supply from drug stocks when the medicine is needed immediately*
- *The Provider shall ensure that there is sufficient medication stored on site at the Unscheduled Care Centre Premises to enable the Provider to be in a position to give to Patients that may require a course of treatment to start without delay the full course of such medication during their visit to the Unscheduled Care Centre Premises.”*

6.301 The GP job description says GPs must prescribe according to national and local PCT guidelines and should *“dispense medication from stock within agreed medicines management protocols.”*

6.302 Care UK standard operating procedure (SOP) for ordering medications, which covers stock control, ordering and management of all medications for Ealing and Brent Urgent Care Centres says:

“The lead nurse and deputy lead nurses are responsible for the ordering, management and stock control of both urgent care centres”

“The ordering of medication will whenever possible be limited to one order a week to aid easier identification of invoices. Emergency orders can take place if needed.”

6.303 The UCC GP induction guide and UCC ‘prescribing bible’ set out the principles for safe prescription of medications (both *“dispensed and given as scripts”*) at the UCC including *“dispense prescription only medications that we have in stock - write scripts for medications that are not in stock”*.

What happens in practice

Direct supply to patients

6.304 The senior pharmacist at the CCG told us that patients attending the UCC should be given medication from stock. Prescriptions should be given only in exceptional circumstances such as if the medication that is needed is not kept in stock or when stock medication has run low.

6.305 UCC staff told us that patients were provided with medication they needed from UCC stock. Medicines were ready-labelled and had patient information leaflets in the box ready to be given to patients in accordance with clinical need. The prescriber wrote on the

packaging the patient's name and the date the patient was supplied with the medication. Details of the medication were added to the patient record on Adastra.

6.306 Patients did not pay for medication supplied directly to them by the UCC. The medications were paid for by Care UK, who were not reimbursed by the NHS Business Services Authority.

6.307 The lead GP said he complied with the contractual requirements to dispense medication but he believed it was sometimes preferable to issue an FP10¹, such as in office hours. He thought that patients who are eligible to pay for their prescriptions should do so, and that providing medication at no cost to the patient contradicted the objective of reducing repeat attendances.

6.308 The CCG told us that as part of the procurement process for the new UCC contract the CCG would be stipulating that FP10s are used during the day and medication is directly supplied to patients at night.

Stock control

6.309 The Care UK pharmacy adviser explained that Care UK had an agreement with the CCG that Care UK would provide approximately 95 of the commonest medications for conditions presenting to the UCC. The list is regularly reviewed by the lead nurse and lead GP with the Care UK pharmacy adviser and updated to take account of changing guidelines, patterns of use and clinical feedback.

6.310 We were told by UCC staff and the Care UK lead pharmacy adviser that the UCC stock levels were set by the Care UK pharmacy adviser and could be adjusted according to need.

¹ FP10 is a prescription form written by prescribers and given to patients who then present them at a community pharmacy for dispensing

6.311 We heard that stocks had run low in the past but this had improved since the beginning of the year when the lead nurse had taken on responsibility for stock control.

6.312 The lead nurse said he did a visual inspection of stock levels every day. The health care assistants (HCAs) carried out a detailed stock check twice a week, or more frequently if necessary, using a template provided by the Care UK pharmacy adviser. The HCAs reported to the lead nurse, who told us that he ordered stock twice a week or more if necessary. The delivery service was one to two days, depending on what time of day the order was placed, and there was no minimum order.

6.313 Care UK lead pharmacist told us that there was no restriction on how much stock was ordered.

6.314 Minutes of the May 2015 contract review meeting record the UCC service manager as saying that the UCC has a certain stock level, which is the maximum it can keep for governance reasons. Key stock items cannot be over-ordered to reduce the possibility of running out.

6.315 The action plan produced by Care UK in response to the allegations states that there are now minimum stock level indicators on drug cupboard doors, with no maximum levels.

6.316 The Care UK medical director for primary care told us that even before the programme there were no maximum stock levels and the pharmacy adviser had set up a system whereby the UCC could order stock daily, with no minimum order and no delivery charge, so it should never run out of stock. She thought that *“people on the ground on a day-to-day basis had not really got round to the mechanics of it”* and that since the Hardcash programme the Care UK lead pharmacist had reminded the UCC of this system and offered her help.

6.317 The Care UK managing director of primary care told us that the lead pharmacist reviewed UCC stock levels immediately after the Hardcash allegations and told the UCC to increase their stocks of drugs. She explained that the levels of stock had not been keeping pace with increasing patient demand. She thought this was a local issue and not related to

the system the lead pharmacist had put in place. She explained that *“Maintaining basic levels of medication is very much part of local operational structure and responsibilities. Although of course, the CQC come in and do their assessments.”*

Prescribing

6.318 We saw documents entitled ‘prescribing audits’ for May 2014, September 2014, January 2015 and May 2015.

6.319 The contract review meeting minutes for 11 September 2015 say:

“The information indicated what was prescribed both from stock and FP10s.”

6.320 The audits note line by line the medications issued by each prescriber in the UCC and compare them with UCC prescribing guidelines, highlighting any problems, including (but not limited to):

- *“Drug prescribed needs urgent review to check appropriate drug and quantity”*
- *“Drug prescribed with potential for misuse although may be fully acceptable”*
- *“Drug was probably a repeat request”*
- *“Query high quantity or quantity not appropriate to dose set”*
- *“Brand prescribed should have been generic”*

6.321 The lead pharmacist told us that she fed back any queries she had about these audits to individual prescribers as part of the *“learning process on appropriate prescribing”*. Following a prescribing audit in April 2015 the lead audit GP wrote to a UCC GP setting out five cases in which there was an issue with his prescribing practice.

6.322 A prescribing budget action plan, labelled ‘September 2014 v3’ links to a document summarising a review and analysis of prescribing data gathered by Ealing CCG undertaken by the Care UK lead pharmacist. Prescribing issues identified include: high levels for diabetes; non-urgent treatments; excessive quantities, including drugs with misuse

potential; brand names and over-the-counter medications. The action plan notes that the following have been completed:

- analysis fed back to local management team;
- medicines management training and refresher October 2014;
- inappropriate prescribing communicated back to individual staff members;
- medicines kept in security coded drugs room; and
- repeat prescribing audit March 2015.

6.323 Documents the CCG provided show it has an annual budget of £30,000 for FP10s issued from Ealing UCC. It overspent by 33 per cent in March 2015. Minutes of the contract review meeting in October 2015 say:

“The projection for July is that the UCC will be 13 per cent below its budget, compared with being 64 per cent over budget in July 2014. The CCG recognised Care UK’s efforts in reducing prescribing on FP10s”.

6.324 Prescribing data for Ealing UCC from April 2014 to March 2015 show formulary prescribing of 6,661 items at a cost of £12,329 and non-formulary prescribing of 18,427 items at a cost of £27,702. The number of items prescribed is higher than the previous year (2013-14) - 3,264 and 5,818 respectively. Minutes of the contract review meeting of March 2015 record:

“[the CCG lead pharmacist] explained that there is a need to look at the breakdown between formulary and non-formulary items, as the intention is that prescriptions shouldn’t be written for formulary items that are already part of the UCC’s stock. The UCC general manager¹ responded that the data will need to be looked at, as it could be that formulary items are being prescribed at times when the stock has run

¹ Initials quoted in minutes have been replaced with job descriptions for clarity.

low, e.g. over bank holidays when GP surgeries are closed and more patients attend the UCC requiring prescriptions”.

6.325 Minutes of the contract review meeting on 11 September 2015 say:

“...it was emphasised that clinicians should be prescribing from stock and not FP10s. FP10s were only as a default. It was Care UK’s responsibility to ensure there was adequate stock at all times.”

Reconciling and stock control

6.326 UCC staff told us there was no process for reconciling medication supplied from stock directly with individual patients or practitioners. Such medication is recorded in individual patient records on Adastral but no central log matches medication supplied to patients with stock levels. The Care UK lead pharmacist told us that the Adastral system could create a report listing all drugs directly supplied to patients but we saw no evidence of this in practice. The “*prescribing audits*” appear to cover both prescribed and supplied medications. We asked how misappropriation of stock medication could be identified. The lead pharmacist for Care UK said:

“We could look at our monthly use on Adastral of the drugs and we could look at the monthly stock that has been ordered, to see if we can reconcile the two.”

6.327 The UCC does not use the FP10P REC forms. The Care UK pharmacy adviser said that the FP10P REC forms had two uses. One was to allow reimbursement from the prescription pricing authority (PPA) for directly supplied medication if the contract covered it. The other was if the UCC had to provide information to the NHS Business Services Authority for audit purposes. She said that neither contractual requirement applied here.

Controlled drugs

6.328 Controlled drugs on Schedule 4 and above are locked in the CD cabinet. The UCC has a key safe and a register must be signed to get the keys from it. The shift lead undertakes audits of the CD stock every morning and a stock reassessment is done whenever anybody takes out a controlled drug. This is always witnessed - i.e. done in pairs.

The allegation that there is a shortage of medicines at the UCC

6.329 Seven of 14 patients surveyed told Healthwatch Ealing that the medicines they needed were not available at the UCC.

6.330 The lead GP told us that UCC managers had noticed that stocks could be low “*at times*” and so they kept a separate stock of essential medications in the controlled drugs cupboard. He acknowledged that other non-essential medications could “*run out*”.

6.331 A UCC GP told us that he could not remember a situation where he was unable to give a patient the medication they needed because the UCC had run out of stock. He explained that if a particular medication had run out he could usually give them an alternative.

6.332 Another GP told us that the UCC had only run out of medication once or twice in his experience and that this had not been in the last few months. He explained that if the UCC did not have enough medication to give to a patient in pharmacy hours he would issue an FP10 and out of hours he would give the patient the enough medication to last them until the pharmacy reopened and they could pick up a prescription.

6.333 Up to date OOH pharmacy information is available to patients in Ealing UCC.

6.334 A nurse told us of a problem with maintaining stocks of an expensive medication necessary for treating children with severe asthma. The incidence of asthma varies seasonally and stock had run out one weekend because of high demand.

6.335 UCC staff told us about the safeguards to ensure patients received necessary medication if UCC stock ran out:

- a separate stock of some antibiotics, painkillers and inhalers was kept in a locked emergency supply that senior staff could access;
- the neighbouring UCC at Brent could send medication by courier if necessary and subject to availability;
- clinicians can also ask for assistance from the ED; and
- an FP10 can be issued to be dispensed at a community pharmacy.

6.336 The lead nurse told us:

“If you see on that programme when they took that little clip, the healthcare assistants were actually in the process of stocking up, so that clip is very misleading because there is not even a single time that we would ever run out of paracetamol, but if you see on there, there are only a few boxes of paracetamol. What they do is when they are checking the medication, they check the expiry dates as well so they have to take everything out, count them, check the expiry dates and then put them back in.”

6.337 The Hardcash reporter agreed that this particular footage had been filmed when the healthcare assistants were stocking up the cupboards. The Hardcash producer said they had more than one example of footage of empty medicine shelves and that their allegation was based on more evidence than just the piece of film the lead nurse is describing.

Comment

National guidance recommends that medications should be supplied directly to patients and an FP10P Rec issued in an out-of-hours situation if a patient needs the medication immediately (e.g. pain relief or because a delay would compromise care).

However, in normal pharmacy hours patients should pay for prescriptions and an FP10 should be issued where this meets the patient's clinical needs.

The contract complies with this national guidance except that it does not refer to FP10P Recs and their use in monitoring medication directly supplied to patients. The contract complies with national guidance but the CCG expects that medication should always be supplied directly to patients where it is available. The UCC local policy and practice comply with this guidance to supply medication to patients when it is in stock, otherwise FP10s are issued. FP10P Recs are not used for medication supplied directly to patients.

National guidance is clear that prescriptions should be paid for. The current system of supplying stock medication to patients who do not pay for it conflicts with the CCG strategic object of discouraging repeat attenders and encouraging patients with long-term conditions such as diabetes to consult their GP. It also excludes the important role of community pharmacists in patient safety.

A preferable system would be one in which patients are issued with FP10s in normal office hours, where the medication is not immediately required and is supplied directly to patients out of hours. Patients should always pay for their prescriptions unless they are exempt. Our clinical advisers suggested some methods they had seen used elsewhere: payment could be collected either at the time the medication is supplied (for example, patients pay at a machine that provides them with a slip, which they exchange for medications) or patients could be informed that they will receive an invoice.

UCC staff told us that stock control had improved since the lead nurse took over but we found no objective evidence to support or refute this. Stock levels are set by the Care UK pharmacy adviser, and although we heard that they could be adjusted in response to clinical need, we did not see evidence of a systematic regular and reasoned proactive review of maximum stock levels.

Although the prescribing audits list prescribing issues that the auditor should look for they do not set out clearly the rationale, methodology, outcomes, learning or action plans. We have seen evidence that the UCC feeds back issues raised in these audits with individual practitioners but it is not clear how individual prescribing and supplying trends are measured over time.

The UCC historically overspends on its prescribing budget and a snapshot view in May 2015 identified significant numbers of prescriptions for stock medicines. A UCC manager explained in a contract review meeting that the prescribing overspend could be a result of stock running low. On balance, we agree with this assessment. The number of formulary items prescribed in 2014/15 was more than double the level of the year before; the number of non-formulary items was more than three times higher over the same period. We saw no evidence to explain this increase.

The presence of the CCG pharmacist at contract review meetings has provided robust challenge to UCC prescribing patterns.

The UCC can tell what medication is supplied to patients from stock but it has no means of reconciling stock levels, so theft or misappropriation would not be identified. Stock includes drugs susceptible to misuse, such as tranquilisers and strong painkillers. A system for reconciling the medications dispensed to patients should be introduced. This could be via FP10P Recs or another suitable method.

On balance, we think that medicines stocks at the UCC sometimes ran low at the time of the Hardcash programme and we therefore support the allegation. However we heard no evidence from clinical staff that they were unable to give patients the medication they required as a result of this shortage or that patient care was adversely affected. The number of prescriptions issued and the anecdotal evidence of UCC staff suggests that the frequency with which the UCC runs out of stock could be reduced. However, the UCC has other ways to acquire medication when stock runs out. We heard that Care UK had taken steps to ensure that the UCC could order medication daily without delivery charge to ensure that supplies did not run out, but the UCC had not made maximum use of the contract in optimising stock levels. This could be related

to conflicting advice in the Care UK SOP that ordering medication should be limited to one order a week if possible. Care UK directors told us that since the allegations the pharmacy adviser has ensured that the UCC now understands the process.

Recommendations

R18 The CCG should review the UCC contract wording about prescribing and supply of medication to align it with their strategic objectives of reducing inappropriate UCC attendances. Patients should pay for their prescriptions and medications unless they are exempt.

R19 UCC managers should regularly check stock levels of medication against quantities supplied to patients and investigate any shortfalls or discrepancies. This should start within the next six months.

The allegation: a vulnerable patient was treated inappropriately by a member of staff at the UCC

6.338 The letter of allegations from Hardcash Productions described an incident in which the lead nurse in the navigator role at reception and in the company of the undercover reporter spoke to a man at reception in a dismissive manner. Hardcash agreed with a CCG request to remove this scene from the programme before it aired as it would not be in the patient's best interests for it to be public.

National policy

6.339 CQC Regulation 10: Dignity and respect, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10:

“When people receive care and treatment, all staff must treat them with dignity and respect at all times. This includes staff treating them in a caring and compassionate way

All communication with people using services must be respectful.”

6.340 The Nursing and Midwifery Council (NMC) *The code: professional standards of practice and behaviour for nurses and midwives* (2015) puts a strong emphasis on “prioritising people”:

“You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.”

Local policy

6.341 The UCC contract says the provider shall “ensure that all vulnerable adults are assessed for any risk of harm, neglect or abuse in line with local policies and procedures specifically the local Protection of Vulnerable Adult policies.”

6.342 The Care UK *Privacy, dignity and respect policy* (2013) lists a number of “dignity tests”:

- *“Care UK staff are polite and courteous even when under pressure;*
- *Care UK has a culture about caring for people and supporting them rather than being about ‘doing tasks’.”*

What happens in practice

6.343 The Hardcash letter sent to Care UK on 22 June sets out the conversation between the vulnerable patient, the lead nurse and the reporter. We have not included the detail of this conversation in this report in order to ensure that the patient cannot be identified. The lead nurse was in the navigator role and the undercover reporter was sitting with him. The vulnerable adult asks the lead nurse a question. The lead nurse asks the undercover reporter a question about the vulnerable patient in front of the patient. The lead nurse tells the patient that he and his colleague agree the vulnerable patient is fine and the patient leaves. As the incident has been removed from the programme we have not been able to assess whether the manner of the lead nurse was appropriate.

6.344 We spoke to the lead nurse about the incident. He told us that the patient was known to mental health services, regularly attended the UCC and was known to UCC and ED staff. Sometimes the patient would come in to speak to the mental health nurses. On other occasions the patient wanted reassurance from the UCC. The receptionist or navigator would reassure the patient and the patient would leave. The lead nurse explained why he had involved the undercover reporter in the conversation:

“I didn’t know I was doing anything wrong because I thought she was a medical student and I thought she was potentially going to be a member of staff. The interaction was I was actually standing there right next to her so she wasn’t left alone. Anywhere you go, medical students are actually asked to go and assess and do clinical assessments.”

6.345 The service manager said:

“We see a lot of repeat attenders here who are very familiar with the staff and if that scenario is taken out of context, it can look like we are over-familiar with patients, which does not look good ... I have no concern about how patients are treated here: vulnerable patients and normal patients as well.”

6.346 Care UK advised us that following the programme Care UK's safeguarding lead and the CCG safeguarding lead had had initial discussions and agreed that any decision to inform the patient should be made in the context of a safeguarding protection plan. Care UK decided with the CCG not to contact the patient because it would not be in the patient's best interest, especially as all reference to the individual had been removed from the programme. Care UK advised us that the lead psychiatric consultant at Ealing hospital is preparing guidance for the UCC on the most appropriate management of frequent attenders and who should be informed about their regular attendance. Once this advice is produced, the UCC will create 'special patient notes' for frequent attenders in Adastra, including appropriate pathways, actions, care plans and contact details for the treating clinicians.

6.347 The Care UK action plan produced in response to the Hardcash allegations updated in October 2015 says *"it was agreed that at times of high activity the long shift at the front desk impacted on the attitude and response by staff to patients"*.

6.348 The log records a number of completed actions:

- all reception team attended customer service training;
- lead nurse asked staff to reflect on attitude and language used at the front desk, especially with repeat attenders;
- navigation shift reduced to four hours in the rota; and
- reception staff rota reviewed to ensure no long shifts.

6.349 Care UK confirmed it was about to develop a face to face training package from an external provider for all frontline staff to help UCC staff identify and support patients with additional needs.

Comment

The lead nurse and other UCC staff knew the vulnerable patient and they responded to the patient's regular queries in a way that reassured the patient.

We did not see the footage of the incident that formed the basis of the allegation and so make no judgement about whether the clinician's manner towards the patient was sufficiently respectful. In response to the incident, Care UK have developed guidance with the adult and child safeguarding leads at the CCG for the UCC about the appropriate management of vulnerable patients who may attend frequently.

The lead psychiatric consultant at Ealing hospital is developing guidance for the UCC about the appropriate management of frequent re-attenders. The UCC plans to put in place a way of recording frequent attenders in Adastra. This should be used to record all occasions when frequent attenders visit the UCC and the outcome. The frequency and any changes in the patient's demeanour should be reported to the mental health team. If the patient came in particularly distressed, we would expect his or her needs to be assessed by the mental health team.

This practice should be adopted for all repeat re-attenders.

The allegation: Care UK did not ask for the reporter's references, background checks or ID and she had unsupervised access to the whole UCC including the medicine cupboard

National policy

6.350 No national policy covers background checks for work experience students or volunteers in healthcare, though the role and management of volunteers in hospitals was the subject of a recommendation in the independent report for the Secretary of State for Health into lessons learnt from NHS investigations into Jimmy Savile:

"All NHS trusts should review their voluntary services arrangements and ensure that volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision."

Local policy

6.351 The UCC contract makes no reference to checks required of work experience students.

6.352 The *Care UK work experience policy* (2014) explains that students are not required to undergo criminal record checks if the placement is less than 15 days and there is no requirement to take up references. The policy says work experience applicants should complete an application form, which should be submitted to Care UK HR. Applicants should also go through a formal interview. Students should sign a confidentiality form during induction. It goes on to say “*on no account are students on a school work experience scheme allowed to deliver hands on care at any time*”.

6.353 A new policy entitled *Care UK work experience for medical students policy* was issued in July 2015. The policy is aimed at students on work experience placements with Care UK who intend to apply to medical school. A number of checks in this policy did not exist in the 2014 policy. Prospective students must:

- provide a reference from their “*student’s sponsor*”;
- supply proof of identity;
- undergo criminal record checks (DBS) prior to commencement of work experience; and
- sign an honorary contract in advance of the placement.

6.354 The statement about work experience students delivering hands-on care has been amended as follows: “*on no account are students on a work experience scheme allowed to deliver hands on care at any time*”.

What happens in practice

6.355 The service manager explained how the undercover reporter had contacted the UCC, presenting herself as someone who wanted a career in medicine and who wanted to do work experience at the UCC.

6.356 The service manager explained that she had sent the reporter's CV to the lead GPs who agreed that she could come to the UCC. She told us this was the usual process. The reporter's CV was not sent to Care UK's HR team before she started her placement.

6.357 Neither Care UK HR nor managers outside the UCC were informed about the placement before the reporter started at the UCC.

6.358 The service manager explained that it was not Care UK policy at the time to do Disclosure and Barring Service (DBS) checks or check references for work experience students. On this occasion, she tried to check the reporter's references when the reporter had already started work experience. She called two referees but neither was available nor called her back. The Hardcash reporter told us that her referees were not contacted until after she had left the UCC.

6.359 We found no evidence in the ITV Exposure programme nor have UCC staff told us that the reporter had unsupervised access to the UCC and medicines store. The Hardcash reporter told us that although she was not supervised, she was never really alone at the UCC except when sometimes GPs left her with patients for short periods while they went to get medicine.

6.360 The service manager told us that the medicine store room had a keypad lock and the reporter would have needed to be accompanied by staff in order to access it. The reporter told us she did not have unsupervised access to the medicine store.

6.361 A number of Care UK managers and directors told us that an unfortunate consequence of the Exposure programme was that Care UK was unlikely to take work experience students in the future.

Comment

The application process applied to the undercover reporter was not in line with Care UK policy. The reporter was not required to complete an application form. Instead, she submitted a CV that HR did not receive before the placement started. She was not interviewed.

The undercover reporter was involved in care during her encounter with the vulnerable patient at reception (see earlier section). This was not in line with local policy. The lead nurse told us that the undercover reporter was involved because he was under the false impression that the reporter was a medical student. UCC management should have clearly told all staff the nature of all work experience students, including what tasks they should be involved in and what supervision was expected.

The work experience policy has been amended - presumably in response to the allegations - and is now more rigorous, including obtaining references and DBS checks for all students.

We support the allegation that Care UK did not ask for the reporter's references, background checks or ID and she was at times unsupervised with patients. She did not have unsupervised access to the medicine store.

The allegation: Care UK has fallen short of standards expected of a provider of out of hours (OOH) services to the NHS and there is an existing risk to patient safety

6.362 We address standards and patient safety in investigating the other allegations.

6.363 After the ITV Exposure programme, the CCG conducted a clinical visit on 6 July and found:

“At the time of the visit our clinical view was that there was no immediate action

that needed to be taken to maintain clinical safety, as we were reassured by the responses given to our questions relating to patient safety and clinical governance. Although there are areas (as above) that require attention.”

6.364 Our clinical advisers raised one other patient safety issue related to nebulising, which we discuss below.

National policy

6.365 The CQC privacy and dignity guidance says *“staff must make sure that people have privacy when they receive treatment”*.

6.366 The NICE clinical knowledge summaries for *Scenario: Acute asthma exacerbation* are clear that when deciding whether to admit a patient (including those with moderate asthma exacerbation) a number of factors should be assessed and recorded:

- pulse rate (increasing suggests worsening asthma, whilst a decrease indicates a life-threatening situation);
- respiratory rate and use of accessory muscles;
- degree of wheeze (less apparent with increasing obstruction); and
- degree of agitation and consciousness.

Local policy

6.367 There is no local policy related to nebulising patients. Care UK confirmed that clinicians currently follow NICE guidelines.

What happens in practice

6.368 The UCC treats some patients who need nebulising. The lead GP explained that this could be someone with a mild to moderate exacerbation of asthma, who had not responded to treatment with inhalers. He explained that severe asthmatics, anyone gasping for breath would be navigated straight to the ED.

6.369 Such patients navigated to the UCC who require nebulising would be nebulised in the corridor outside the treatment and HCA rooms. This area is separate from the waiting room but a number of patients may be waiting in it at a given moment.

6.370 The lead GP thought the current system of nebulising patients in the corridor worked well because there was a *“good footfall of clinicians regularly walking through there who can keep an eye on those patients”*. He explained that these patients were the responsibility of the clinician who initiated the treatment. He acknowledged that there could be a risk if the assessment nurse instigated the nebuliser and marked the patient has urgent without handing the patient over to treating clinicians. However he said that this did not happen in the vast majority of cases.

6.371 The lead audit GP explained that people with *“extreme respiratory distress”* were excluded from the UCC and that patients being nebulised in the UCC would be *“stable but wheezy”*. He acknowledged that it would be *“ideal to be able to supervise them”*.

6.372 A document titled *Learning points Brent and Ealing clinical education meeting on Wednesday 22 January 2014* under the title *“asthma management”* one of the points was: *“Mark all patients requiring nebuliser as urgent as more likely to need ED referral and either monitor closely or hand over to another clinician.”*

Comment

The current system of patients being nebulised in the corridor without supervision means that the UCC clinicians are not able to monitor whether a patient's symptoms

are changing and leaves them open to the risk that the patient may deteriorate, while also compromising the patient's privacy and dignity.

Recommendation

R20 The CCG should consider whether to require, as part of the new contract, that any patients being nebulised in the UCC are treated with direct supervision in a separate treatment room.

The allegation: underfunding of OOH GP services can lead to serious consequences

6.373 It is not in the remit of this review to assess whether OOH GP services in general are underfunded - we have therefore not investigated this allegation.

7. Commissioning arrangements

7.1 In this section we review the commissioning arrangements between Ealing CCG and the UCC. We examine the contract, the CCG's monitoring and assurance processes and information sharing.

7.2 In section 6 we reviewed the CCG involvement in some of the topics associated with specific allegations. We sought to reference these instances rather than duplicate material in this section.

Board assurance

National policy

7.3 NHS England guidance¹ says that *“a great CCG will have a clinical focus perspective threaded through everything it does, resulting in having quality at its heart, and a real focus on outcomes”*. It goes on to say that clinical outcomes and quality should be integral to commissioning plans and decisions and that CCGs should have in place *“a comprehensive range of systems and processes to ensure increasingly timely information and relevant incentives to drive continual improvement in clinical quality - both within constituent practices and the services which are commissioned”*. Clinicians should *“use clinical knowledge of local care pathways to increase the appropriateness of care, make best use of available resources and improve population health”* and that CCGs should have a *“systematic approach to monitoring delivery of commissioning plans, including quality, outcomes and reducing inequalities”*.

¹ Developing clinical commissioning groups: towards authorisation, NHS England, 2011

Local policy

7.4 The eight North West London CCGs produced a joint five-year strategic plan for 2014/15 to 2018/19¹. It says *“the CCGs of NWL are responsible for the quality assurance of the provider organisations they commission from, ensuring they are held to account for the delivery of quality standards and contractual obligations. NWL has developed Quality Strategies that set out approaches to embedding quality in every part of the commissioning cycle”*.

7.5 Referring to the nine UCCs in North West London, the strategic plan says *“the UCCs will be fully integrated with the wider integrated and coordinated out-of hospital system to ensure appropriate follow up. They will have strong links with other related services, including GP practices and pharmacies in the community. They are also networked with local A&E departments, whether on the same hospital site or elsewhere, so that any patients who do attend an UCC with a more severe complaint can quickly receive the most appropriate specialist care at another NWL A&E. As part of SaHF, all Urgent Care Centres in NWL will operate based on a common specification and to a common set of clinical standards. The UCC specification will also ensure that future care meets the needs of all service users but particularly those protected groups and hard to reach communities affected by A&E transition.”*

7.6 Ealing CCG published ‘Commissioning Intentions’ for 2015/16. These say the CCG expects all providers to achieve *“improvement in specialities response times to A&E and UCC referrals. Jointly improve pathways and sustain management of late referrals from UCC to A&E and specialities. Reduction admissions made due to diagnostic waits”*.

¹ Transforming the NHS in North West London, NW London CCGs, 2014

What happens in practice

7.7 The Ealing CCG governing body is made up of elected members from GP practices, representatives from social care and public health in Ealing, a secondary care consultant, lay members and CCG directors including the chief officer, chief finance officer, the CCG acting managing director and the director of nursing, quality and safety.

7.8 The governing body is the highest decision-making body in the CCG and is accountable to the CCG council of member practices and NHS England. It meets every two months and considers information about the services and providers in Ealing. The governing bodies as set out in the Ealing CCG constitution (May 2015) functions include:

- *“Ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance (its main function);*
- *Approving prior to the start of each financial year the total allocations received and their proposed distribution including any sums to be held in reserve;*
- *Approving a commissioning strategy, which takes into account financial targets and forecast limits of available resources;*
- *Receiving from the Chief Finance Officer on behalf of the CCG prior to the start of the financial year the budgets for approval;*
- *Receiving and reviewing the chief financial officer regular reports on the financial performance against budget and plan including any significant changes to the initial allocation and the uses of such funds.”*

7.9 The governing body has a number of committees, including:

- the finance and performance committee: their remit is to provide assurance to the governing body that financial plans are robust and that risks to delivering financial, performance and QIPP¹ obligations are being managed effectively; and
- the quality, patient and safety committee which provides assurance to the governing body that there are effective arrangements for monitoring and improving safety and quality of care that is commissioned by the CCG. It informs the governing body of any risks that could impact the quality of care provision and any actions that have been put in place to mitigate these risks. It meets on a monthly basis.

7.10 The governing body recently agreed to integrate performance and quality into one committee. The Ealing CCG chair told us that this was in order to improve the CCG's understanding of quality issues.

7.11 According to its terms of reference, the management and innovation committee meet at least once a month, are accountable to the governing body and have responsibility for managing the day to day operations of the CCG.

7.12 For each large acute provider commissioned by the CCG there is a corresponding clinical quality group (CQG). CQGs are made up of commissioners and providers and meet monthly. They enable commissioners and providers to jointly monitor and manage clinical quality and patient safety issues and to identify any areas for clinical service development, improvement and innovation.

7.13 The CQGs report to the quality and patient safety committee. There is a CQG for London North West NHS Healthcare Trust (the trust) which includes Ealing hospital, as with other major providers, but no separate one for the UCC.

¹ QIPP stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS.

7.14 An Ealing CCG integrated performance and quality report is produced each month and includes:

- Information on CCG and provider performance against national standards including the four-hour A&E target. It includes an Ealing UCC exception report that sets out performance against the UCC contractual KPIs, root causes of underperformance, actions being taken to mitigate, assurances and any gaps in assurance.
- Quality and safety exception reports and actions for acute, community and mental health providers. Quality and safety metrics include serious incidents, ‘never’ events, Summary Hospital-level Mortality Indicator (SHMI), maternity services, complaints and patient experience. Quality and safety metrics for the UCC are not included in the quality and safety section of the report.

7.15 The integrated governance report is presented in full at the quality and safety committee and exceptions are discussed. The information contained in the report is two months old but linked with up-to-date quality issues for each provider from the CCGs. We were told by the Ealing CCG chair that for the UCC this up-to-date intelligence comes from the acting assistant director of unplanned care or the managing director or deputy MD who bring information from contract review meetings with the UCC (these meetings are discussed below)

7.16 The committee also discusses a monthly Serious Incident (SI) report, quarterly complaint report, safeguarding and patient experience information.

7.17 In addition, the integrated performance and quality report is available with the governing body papers, usually for a month two to three months before the governing body meeting. For example, in November 2015 it considered the report from August 2015.

7.18 The acting managing director told us that the integrated performance and quality report provided the governing body with an opportunity to ask her about UCC performance. However, she explained that conversations at that level tended to focus on: high-risk quality issues; acute, mental health and community provider performance; and standards such as “RTT, A&E, Cancer” that the CCG is measured on.

7.19 UCC performance and quality between October 2012 and June 2015 are not mentioned in part 1 governing body minutes. We were not provided with the private part 2 minutes of the governing body.

7.20 The acting managing director told us that more detailed discussions about performance took place at the finance and performance committee. Discussions had taken place recently about UCC underperformance against the assessment KPIs. This resulted in the UCC taking steps to address underperformance. We discuss this in section 6.

7.21 We looked at quality, patient and safety committee meeting minutes between October 2013 and June 2015. Ealing UCC was referred to twice in this period. The first time was in January 2015, referring to staffing issues and the second was in March 2015 related to assessment KPIs. We discuss staffing and assessment KPIs in section 6.

7.22 The director of nursing, quality and patient safety for Central London, West London, Hammersmith and Fulham, Hounslow and Ealing (CWHHE) CCGs, told us:

“I’m very clear from a governance perspective that there is a very clear line from the Sub Committee to the Governing Body. All our committees and groups that meet, that’s Clinical Quality Group for each of our contracts, there is a very clear line to the governing body from an accountability perspective.”

7.23 The acting managing director explained that the committees that discussed the integrated performance and quality report did not discuss each provider contract that the CCG commissioned but gave committee members the opportunity to discuss performance and quality metrics that were ‘red’ rated. She told us that the CCG were looking at ways to make the report more digestible.

7.24 She also told us that they were updating their board assurance framework to include the risks associated with the UCC and other similar services.

7.25 She also acknowledged that the CCG performance and quality assurance processes needed strengthening so that the CCG could be assured that information from the breadth of the services it commissioned was followed up and used to determine risks associated with them. She said one of the challenges was to effectively utilise the CCG workforce across the five CCGs to get “economies of scale”.

Comment

The CCG has a clear line of accountability for performance, quality and safety assurance. However, we have found that UCC quality and safety information does not reach the governing body other than that contained in the minutes of the quality and safety committee and the finance and performance committee.

A UCC exception report including performance against contractual KPIs is included in the integrated performance and quality report considered by the finance and performance committee and the quality and patient safety committee. Both committees discussed UCC assessment KPIs this year.

However, it is not clear how the CCG assures itself about the quality and safety of the UCC service. The quality and safety section of the integrated quality and performance report includes exception reports for acute, mental health and community providers for quality metrics but does not appear to include similar quality metrics for UCC.

The integrated performance and quality report is a large report for committee members to absorb and discussions are confined to exceptions. The CCG is considering ways to make this report more digestible. Unsurprisingly, discussions are focused on large acute providers.

However, the UCC sees many patients and acts as a feeder to the ED at Ealing hospital and we think it represents a higher risk than most primary care services and data should be reported accordingly.

Recommendation

R21 The CCG should amend the integrated performance and quality report within the next two months so that it includes UCC quality and safety information.

Contract monitoring

National policy

7.26 The UCC contract stipulates that the services are required to meet the quality requirements set out in *National Quality Requirements in the Delivery of Out of Hours Services* published July 2006, and any subsequent publications. We discuss in section 6 some of the specific quality requirements set out in this guidance as they relate to the allegations. The guidance says all providers must report regularly to PCTs (as they then were) on their compliance with quality requirements. It also sets out compliance levels against the quality requirements.

Local policy

7.27 The UCC contract sets out requirements for anyone providing the service, their training, appraisal and assessment. It specifies requirements for prescribing and provision of drugs, medicines and appliances.

7.28 We discuss in section 6 some of the UCC contractual KPIs as they relate to specific allegations. Other examples include:

- 98 per cent or more of patients who require diagnostics are referred for diagnostics within two hours of arrival;
- 100 per cent of patients with asthma have a set of baseline observations that include pulse, oxygen saturation rate, peak flow and respiratory rate (as a minimum) which

should then form part of the information (received by electronic transfer) by GPs/health visitors and school nurses; and

- 90 per cent or more of patients are satisfied with the service.

7.29 The UCC contract stipulates that the UCC must monitor its performance against the contractual KPIs and submit a monthly exception report to the PCT (now CCG) contract manager. The exception report should include:

- the KPIs which the UCC anticipates achieving a performance rating of band B or C for the quarter and the corrective action the UCC has implemented or intends to implement to improve the rating;
- any adverse incidents or untoward events;
- any adverse reports from statutory or non-statutory bodies; and
- any patient complaints related to UCC services.

7.30 The contract also stipulates that the UCC must submit provider performance reports on a quarterly basis. These reports should include performance on all KPIs, explanations and corrective actions for any on which the UCC is underperforming. Explanations and corrective actions for any adverse incidents or untoward events should also be provided.

7.31 The contract also stipulates that quarterly Joint Service Reviews should take place and that as a minimum the PCT (now CCG) contract manager, PCT (now CCG) clinical lead, Care UK's contract manager and Care UK's medical director should participate and attend. Discussions should include provider performance and performance reports, KPIs, any reports from statutory or non-statutory bodies, any complaints and the progress by the provider in respect of corrective action and rectification plans for any of these.

7.32 It also says the Joint Service Review will decide:

- *“whether or not the failure to comply with KPIs has been caused by the provider’s:*
 - *poor performance; and/or*
 - *breach of this agreement; and/or*

- *clinical negligence;*
- *whether the provider's performance necessitates the implementation of sanctions."*

7.33 The UCC contract provides that the PCT (now CCG) can apply the following sanctions to the provider:

- termination or suspension of any part of the agreement;
- replacement of the provider for up to six months;
- withholding or deducting monies otherwise payable under the agreement; and
- the requirement on the Provider to remedy a breach by re-executing the relevant part of the service free of charge and to arrange all such additional resources as are necessary to perform the services in accordance with the KPIs at no additional charge to the PCT.

What happens in practice

7.34 The CCG acting assistant director of unplanned care is responsible for the UCC contract and the contract manager manages the UCC contract day to day. The CCG acting managing director oversees the contract.

7.35 The UCC submits a daily situation report to the acting assistant director of unplanned care and the North West London CCG Central performance team, detailing the number of attendances and breaches of the four-hour target for the day before. The acting assistant director of unplanned care told us that the North West London central performance team submitted the information to NHS England daily. If the number of breaches was "*significant*" (more than five) the UCC sent her a breach analysis later in the day, explaining the reasons. She told us that this daily reporting was to inform the CCG about the flow of patients, not about performance.

7.36 The UCC sends the contract manager performance reports and a KPI schedule setting out performance against all the KPIs every month.

7.37 The UCC submit Joint Service Review reports quarterly to the CCG. The report includes: information about the staffing model; attendances; KPIs; KPIs in breach of threshold and other significant incidents; complaints; patient experience data; incidents; SIs; audit schedules and audits; and reports from regulatory or non-regulatory bodies.

7.38 Contract review meetings originally took place every two months but since July 2015 the CCG requested that they take place monthly. The meetings are well attended by CCG and Care UK staff. Regular attendees include:

- Care UK: regional manager, general manager, lead GPs, lead nurse and the service manager; and
- Ealing CCG: managing director, acting assistant director of unplanned care, contract manager, senior pharmaceutical adviser, CCG safeguarding leads.

7.39 The minutes show that between August 2013 and July 2015 there has been little to no CCG clinical attendance at this meeting. Dr Raj Chandok, the vice chair of the CCG, attended twice - once in August 2013 and July 2014. He told us that before July 2014 he had been both the urgent care lead for the CCG (sitting on the urgent care board) and the UCC clinical lead. He told us that he discharged his responsibility as UCC clinical lead by attending the monthly urgent care board where urgent care centre performance was discussed. An NHS England directive in the summer of 2014 said CCG chairs should attend all urgent care boards¹. The CCG chair had therefore taken over his position on the board and assumed urgent care lead responsibility for the CCG. At the same time, the vice chair understood that he had stepped down as the UCC clinical lead. He thought there might have been some ambiguity about this and that the CCG chair might have thought he was still clinical lead.

¹ The Urgent Care Board includes all stakeholders in urgent care in the area and is the organisation reviewing the performance of Urgent Care in each CCG

7.40 The vice chair said he was not therefore integral to any performance issues during this time but that the acting assistant director of unplanned care would have *“felt supported by everyone and would have been able to escalate concerns to [Ealing CCG chair] or myself at any time”*.

7.41 The acting assistant director of unplanned care told us she had always been able to access clinical advice if she needed it but that the lack of clinical input had been a gap because she had not always known when to challenge clinical information at the meetings.

7.42 Since the Hardcash allegations the vice-chair of the CCG has attended the meeting providing senior clinical CCG input.

7.43 There had been limited attendance from the quality team until July 2015 due to capacity. The CCG acting managing director told us that prior to the ITV Exposure documentary the decision had been made to recruit a whole time equivalent assistant director for quality improvement and clinical assurance for Ealing CCG who commenced in post in August 2015. Prior to that decision there was a half time funded post.

7.44 Standing items on the contract review agenda are: KPIs; safeguarding; serious incidents; complaints and compliments; patient experience; referral pathways; clinical audit; prescribing. Referral pathways, late referrals to the ED, specialty breaches and UCC staffing levels have also been discussed regularly at these meetings.

7.45 Actions are minuted and each one is discussed at every meeting and added to or closed where appropriate. Some actions remained on the agenda for long periods, sometimes for years. In one case where Care UK requested to move to electronic messaging to GP practices, the action has been continuing for almost two years (this is discussed in section 8). Both the CCG and Care UK have long-standing action points. The acting assistant director of unplanned care told us that she thought both sides wanted to try resolve problems but some things took time. However, she acknowledged changes in CCG representation resulted in her sometimes losing the context and sense of the original action. This meant it was sometimes not clear who was responsible.

7.46 The former Care UK regional director explained that neither the CCG nor Care UK were able to solve some of the problems:

“You have an 18-month old action that no-one seems to want to move forward, so we would say this action is still outstanding, we still have an issue with the relationship with ED and we still disagree with this piece of data. So they write it down, then we go to the next meeting”

7.47 An ED service manager told us she had raised the issue about UCC and ED double reporting of the four-hour target with the CCG in February 2015 (discussed in section 6) and it had been escalated but not resolved by September 2015.

7.48 The acting assistant director of unplanned care told us that the contract meetings were *“good, open, collaborative discussions and sharing of information”*. However, she thought the meeting put too much emphasis on KPIs, especially those where the UCC underperformed.

“Always with KPIs and contracts, they can be quite limiting, and as an NHS organisation in how we do contracts we could be counting the wrong thing. We are into bean counting and really the priority should be around patient experience and the clinical quality and safety of service. We then have some perverse incentives, and that becomes caught up in the contractual bean counting. It is incentivising in a perverse way which really stops what you should be focussing on.”

7.49 The UCC lead GP told us that before the Hardcash allegations the CCG involvement in the UCC has been largely confined to the bi-monthly contract meetings:

“They do ask; they want to know about our complaints, they do want to know about our audits, they want to know about quality assurance. They asked for this sort of evidence at previous meetings but the things that are important to us, to me, that’s not necessarily asked for at these sorts of meetings.”

7.50 He went on:

“I’ve never had a commissioner come to talk to me, a doctor, clinician-to-clinician, and ask me ‘what do you want, what would help’.”

7.51 The lead audit GP told us that the UCC and CCG were not in daily contact but he felt that Care UK could raise concerns with the CCG at the contract review meetings:

“They will always look into it. I don’t think they always give us what we want but obviously they have their own financial and time constraints which I can’t comment on, but they always do look into things. If we ask for x, y and z they will always get back to us, it’s never just thrown out. It’s always okay, we’ll look into this, we’ll do x, y and z and we’ll pick this up again in the next meeting.”

7.52 The acting managing director told us that from a CCG perspective, communication with the UCC was good:

“From our perspective I feel that their avenues are open ...

... Where [the general manager] has had problems he has been on the phone to either [the assistant director of unplanned care] or myself. It feels to me like there are open comms irrespective of the KPI information coming in on a regular basis.”

Comment

The UCC sends monthly reports to the CCG that set out performance against the KPIs but do not provide explanations or details of remedies the UCC is pursuing. This is not in line with the contract. Contractually, the UCC is also required to send a monthly exception report that includes any adverse incidents or reports or patient complaints. The quarterly report should include details of any steps being taken in response to incidents or complaints but it is not currently submitted.

A clinical lead or clinical representative attended only two contract review meetings from August 2013 to July 2015. The acting assistant director of unplanned care felt she could raise clinical issues with colleagues outside of meetings but generally no one from the clinical or quality team was on hand to interpret and act on specific quality and clinical issues. This has been rectified since July 2015. Dr Chandok, vice chair of the CCG, told us that the monthly urgent care board was where the CCG was able to have clinical oversight of urgent care centre performance and quality. The meetings were attended by the chair or vice chair of the CCG.

Actions have remained open for long periods as a result of lack of time on both the CCG and UCC sides but also because some issues have been perceived as insurmountable.

Communication between the CCG and UCC is largely confined to the contract review meetings and some UCC managers feel as though the CCG could be better engaged with the contract.

7.53 The UCC has consistently underperformed on a number of KPIs over the past two years: adult and child clinical assessment, appointment length (discharge within two hours for patients who do not need diagnostics), ED 4-hour wait (patients who are referred to the ED who subsequently breach) and specialty referral. These KPIs are discussed regularly at contract review meetings but there did not appear to be structured actions in response to poor performance and no sustained improvement except in clinical assessment time (discussed in section 6).

7.54 The acting managing director told us:

“We have had some very heated exchanges with them and pushed hard to understand, particularly the KPIs that had been red for such a long time - we have had a lot of conversations about those”

7.55 The acting managing director of the CCG told us that for the last two years of the contract Care UK had not faced financial sanctions for underperforming on KPIs. She told us

that this was due to an agreement reached when Care UK's request for more money had been denied. This issue is discussed in section 6 in the subsection about KPIs being manipulated.

Comment

The UCC has underperformed on a number of KPIs for the past few years. With the exception of the clinical assessment KPIs (discussed in detail in section 6), these KPIs have shown no sustained or significant improvement. The KPIs are thoroughly discussed at contract review meetings and presented to the CCG in reports every month but there is no clear plan about how to resolve underperformance. The CCG has not imposed financial sanctions for underperforming against these KPIs.

It is part of the role of the commissioner to challenge information that providers share with them and to assure themselves that appropriate actions have been taken. However the CCG seems to have largely accepted information from the UCC and should adopt a more challenging approach for testing the information.

7.56 As discussed above, the UCC submits monthly and quarterly reports quality information to the CCG and the acting assistant director of unplanned care told us that quality was an important item on the contract review agenda.

7.57 The director of quality, nursing and patient safety for Central London, West London, Hammersmith & Fulham, Hounslow and Ealing (CWHHE) CCGs Commissioning Collaborative told us information provided at contract review meeting assured the group about the quality of services. He talked about his expectation for the information the CCG should ask for from the UCC and all other providers:

"I am quite focused with our providers around saying 'So if we're asking you for your quarterly report on safeguarding, I don't want you to write a report for us; I want the report that goes to your board, because we want to see the assurance that you are providing to your board. Your own internal governance arrangements are where

we should be getting our assurances from, because at the end of the day a paper is a paper with words on it but actually it's about seeing and understanding how you've had that discussion, how your board have been cited, and assured themselves that actually this is all in place'."

7.58 We discuss serious incident reporting and CCG involvement in the process in section 9.

7.59 As discussed in relation to the allegations in section 6 the CCG receives the UCC audit schedule and a number of audits from the UCC, including x-ray audits and paediatric observations audits. The lead audit GP presents an overview of the audit, results and any actions to the CCG at contract review meetings. However, the discussions do not appear to be detailed and no discussion appears to take place/have taken place about what areas are audited, the schedule and the methodology. We saw no record of documentation or prescribing audits having been discussed. We asked the acting assistant director of unplanned care how vigorously the audits were interrogated and how much these audit reports were challenged. She told us:

"It all depends on the subject areas and what time there is within the one-and-a-half or two-hour meeting and how much time we devote to it, and it can vary. Again, it also depends who's in those meetings."

7.60 She told us that it would be helpful to have clinical input in these discussions. She also said that the CCG did not have systems to influence what was audited and to monitor whether actions following audits were implemented.

7.61 Audits are discussed only at the contract review meetings and are not reviewed by the quality team or any other forum in the CCG.

7.62 The acting managing director told us that she regarded the UCC as average risk among the CCG contracts due to it being an urgent care centre seeing a high volume of patients. She told us that she had no concerns about care at the UCC nor had any concerns been raised with the CCG, to her knowledge, before the Hardcash allegations: "As a system

we haven't had any of the early warnings that we would expect." There had been no concerns raised by the London North West Clinical Quality Group about patients handed over to them from the UCC. Nor had any concerns been raised with the CCG by GPs. She explained that one of the ways that concerns about a provider reached the CCG would be through GPs. They would complain to the CCG because discharge summaries were not being sent to them in a timely manner, were of poor quality or because their patients had told them that care was not good. This had not been the case for the UCC.

7.63 The acting managing director told us that the quality information received from the UCC did not *"paint a bad picture"* but she acknowledged that the CCG had tended to accept the quality information rather than challenging it.

7.64 She told us:

"KPIs tell you about performance, they don't tell you about what is happening sitting underneath that and whether they are an indicator of how well something is performing as opposed to "Is a service safe? Is it delivering quality and does the performance fall out of the back of that?", and that is where we think we have to re-orientate ourselves around, in that order."

7.65 The director of quality, nursing and patient safety for CWHHE CCG Commissioning Collaborative told us about how the CCGs could best identify quality concerns about providers. He explained that KPIs and dashboards are just one source of information. Assurance comes from bringing together information from a number of sources including patients, local stakeholders, Healthwatch and GPs which on its own would not ring alarm bells but looked at together gives a different picture of concern.

7.66 He told us that the CCG desktop review (July 2015) had looked at all the quality information the CCG held on the UCC, including complaints raised with the CCG about the UCC and any serious incidents. He said no specific concerns arose from that review based on the information available at that time.

7.67 He acknowledged gaps in capacity for spotting concerns . He told us that the CCG had recognised this and the need to increase capacity in the quality team and had introduced a new post - assistant director for quality, based solely with Ealing CCG. This had been agreed and an appointment made prior to the ITV Exposure programme. The post holder was in place in August 2015.

Comment

The CCG has relied heavily on KPIs for monitoring the UCC contract, without detailed discussion at contract review meetings about quality. In addition there has been poor representation at the meetings by the UCC quality team or clinicians.

The CCG safety and quality committee relies on receiving up-to-date information on quality and safety from the contract review meetings (in lieu of there being a dedicated CRG). It is therefore all the more important that senior clinicians attend this meeting and that quality and safety are given equal weight as performance.

In section 6 we highlighted deficiencies with a number of UCC audits that the CCG had not identified. Audits are briefly discussed at contract review meetings but no CCG clinician has been present to critically assess the methodology of audits, the results and the schedule and types of audits being submitted. The audits are not considered in any forum outside the contract review meetings. This is a gap in the CCG assurance processes.

The CCG acknowledges gaps in its processes for identifying concerns about quality and it has brought in extra resource to address them.

The director of quality, nursing and patient talked about how information from various sources can be brought together to develop a better picture of the quality and safety of services. The CCG has done this for the UCC in response to the Hardcash allegations.

Recommendation

R22 The CCG should develop a process within the next two months for having input into and critically assessing the UCC audit schedule and for monitoring audit quality and outcomes via their quality team.

8. Care UK governance processes

8.1 In this section, we first examine Care UK governance and board assurance processes and then we consider specific Care UK processes that we identified as significant and which have not already been sufficiently covered in section 6 in relation to the allegations.

Care UK governance processes including board assurance processes for quality and safety

National policy

8.2 The Department of Health defines clinical governance as:

“...a framework through which NHS organisations¹ are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

Local policy

8.3 The *Care UK clinical governance policy within the healthcare division* (2015) sets out the system of clinical governance in the healthcare division and the accountability and responsibilities for governance of various groups and individuals in the healthcare division. It describes the healthcare board:

¹ Care UK consider themselves to be subject to the same framework - set out in their clinical governance policy.

“Through the implementation of quality governance, the board will ensure it promotes a culture where patients are first, staff learn from experience, and the organisation engages with patients and the public to develop services in the future.

8.4 Care UK declined to provide us with terms of reference, agenda or minutes for the healthcare board because they said contained information *“regarding a wide range of services and related confidential commercial content”*. However, the managing director for primary care explained that the healthcare board comprises the group chief executive, the group finance director, the managing director for healthcare, the finance director for healthcare, managing director for primary care, managing director for secondary care, finance director and group chief information officer, the medical director primary care and the medical director for secondary care. It meets monthly and is the primary decision-making body for the healthcare division. The medical directors present their governance report as a standing item.

8.5 The healthcare governance, risk and compliance committee terms of reference set out membership including *“representatives from each division and from the divisional support functions; clinical and medical governance, HR, information governance, and health and safety. Representatives from the group legal team are also members”*. The managing director of healthcare chairs the committee. Meetings are held quarterly and in the month preceding the governance sub-committee of the board meeting.

8.6 A primary care quality, audit and risk committee (QARC), chaired by the medical director of primary care, takes place every two months. The terms of reference describe the QARC as providing the following to the healthcare executive:

- *advice with regard to ensuring the delivery of high quality services to our patients;*
- *supported in embedding quality in its strategic planning;*
- *assurance and monitoring of quality governance within the services provided by Care UK;*
- *identification of potential risks and advice with respect to their mitigation;*
- *advice with respect to staff development programmes that support leadership development and the delivery of quality services;*

- *high quality, robust, relevant and timely information with respect to the performance of services;*
- *regular reporting to the executive team and, where appropriate, to the Care UK Group functions;*
- *integration of the work of individuals programmes and committees that falls within the quality governance agenda.”*

8.7 The primary care QARC chair reports to the overarching healthcare governance risk and compliance committee.

8.8 *Care UK clinical governance policy within the healthcare division (2015)* says the quality governance and assurance meetings for primary care and secondary care must:

- *“Provide assurance to the healthcare board that services are safe, caring, responsive, effective and well led*
- *Sign off clinical governance policies and procedures*
- *Receive monitoring assurance reports from heads of IPC, learning and development, medicines management, safeguarding, governance, HR, performance improvement and health and safety*
- *Make recommendations for improvement programmes*
- *Manage the clinical risk register and agree mitigating actions*
- *Seek direction and guidance from the healthcare board where decisions lie outside their remit”*

8.9 The policy says the CQC registered manager of a service is accountable for ensuring the services they run have clinical governance systems and processes. The medical directors for each healthcare division are responsible for ensuring that the clinical governance and associated policies are monitored.

8.10 The policy sets out the responsibilities of the governance team in providing “*division-wide guidance, facilitation and support*” for elements of the “*integrated governance agenda*”.

8.11 All Care UK services are required to hold monthly quality governance meetings and should discuss: safeguarding, complaints, incidents/Serious incidents requiring investigation (SIRIs), KPIs, patient experience and involvement, health and safety, learning and development, retention and recruitment.

What happens in practice

8.12 The managing director for primary care is responsible for primary care in GP practices, out-of-hours and urgent care centres, prisons and the 111 service. The managing director of healthcare holds the managing director for primary care to account. They meet monthly. The managing director for primary care is responsible for Ealing UCC. She has nine direct line reports including three regional directors, two 'service line' directors for health in justice and NHS 111, a service line director for practices and super practices, medical director, HR director and business development director. She receives month-end reports spanning all her services: a finance report that contains commentary on any key variances, an agency spend report, a turnover report, a HR key metrics report, a contract KPI report and an integrated governance report. She also receives verbal updates from her line reports.

8.13 The regional directors meet once a month for two days, for these one-to-ones and other meetings. This is called the monthly primary care senior leadership team meeting.

8.14 The London regional director is responsible for the Ealing UCC service and until recently was the main head office contact for UCC staff and attended the contract review meetings with the CCG. The UCC now reports to a director of operations who in turn reports to the regional director.

8.15 The London regional director receives the same daily and monthly reports from the UCC that are sent to the CCG for review at the contract meetings.

8.16 The responsibility for governance in Care UK healthcare sits with the responsible officer (RO) - the medical director for secondary care. The medical director for primary

care is the deputy RO. The CQC-registered manager of each service holds governance responsibility at a local level.

8.17 Each regional and service line primary care director has a governance lead. The governance leads report to the regional medical directors who report to the medical director for primary care, who reports to the managing director for primary care.

8.18 All governance leads attend a monthly primary care quality assurance, risk and compliance committee with the medical director, which is the highest level of quality assurance in the primary care function. The governance manager told us that the committee discussed *“how the services are managing from an overall governance perspective”*.

8.19 The managing director of primary care reviews the integrated governance report every month. It is a dashboard covering a range of key metrics including:

- patient experience survey rate;
- friends and family recommend score;
- complaint rate;
- incidents are reviewed within 72 hours;
- CQC compliance;
- CQC registered manager in place;
- statutory and mandatory training compliance;
- clinical audits are completed;
- sickness hours as a percentage of contracted hours;
- staff turnover (rolling 12 month);
- clinical vacancies; and
- non-clinical vacancies.

8.20 Each metric has thresholds, which enables each to be risk-rated red, amber or green. Thresholds are based on external standards, for example those set by the CQC. If no external standards exist, the thresholds are agreed by Care UK directors. For example, the threshold for complaints is 0.8 per cent of attendances.

8.21 The managing director of primary care shares the integrated governance report with the directors across all the primary care services. She follows this up with individual emails to these directors, questioning specific issues of note in the monthly report. This is followed up by a monthly one-to-one meeting to identify and agree on corrective actions resulting from issues identified in the monthly integrated governance report. The managing director of primary care follows up at the next month's one-to-one to see whether progress has been made.

8.22 Care UK directors told us that the primary care QARC and the healthcare board consider the integrated governance report. We were also sent the healthcare quality governance report summary for 2015-2016 and the primary care governance summary October 2015 and were told that these were shared with the healthcare board.

8.23 The medical director for primary care told us that the governance structure had changed in the last year (i.e. before the allegations). The governance manager explained the restructure:

“the governance managers are more locally embedded. Before the governance managers belonged to the corporate team, so they did top-down scrutiny, whereas we are now reporting directly into the regional medical directors, so we are much more part of the operational team ... The governance is much more operationally-focused and asking a lot more questions ...

... I would suggest in that restructure of that governance it has been a lot more open, a lot more transparent, a lot more aware and proactive

... It has now become very much embedded, so from the medical director, managing director, I think they are much more in touch and much more aware probably on a day-to-day, they are much closer, and it's much quicker and easier to feed up things that are going on, I think they have much better sight.”

8.24 Joint Brent and Ealing clinical governance meetings are held monthly. Attendees include UCC clinical and managerial leads and the governance manager for the London region. The current governance manager started to attend the meetings in April 2015. The governance manager reports any issues that need escalation to the primary care quality assurance, risk and compliance committee. The medical director then escalates any issues to the healthcare division board.

8.25 The governance manager told us that the joint governance meetings needed to be made more dynamic and proactive:

“... when I first arrived it was a very short meeting, with limited topics being discussed; since I have been in post I have increased it to monthly, because it was only being held bi-monthly, and I’ve increased it from an hour and a half to three hours, to make it more robust. I would say that it is in its infancy as to what is discussed and how it is discussed. We have an overarching agenda, where we will look at compliance with the training, complaints, incidents, audit, so we have a high-level agenda to look at, so we will go through that, people will bring information to that meeting, but it is a work in progress.”

8.26 Care UK uses Datix to record and report all incidents and complaints at the UCC. The regional medical director, governance manager, lead clinicians and managers in the UCC get a notification whenever staff in the UCC add something to Datix. The governance manager told us that this allows her to follow up with the UCC, get more clarity and check they are progressing actions properly.

8.27 The UCC is required to report compliance with their audit schedule to Care UK directors and governance managers as part of a monthly integrated governance report and in July 2015 Care UK set up a Clinical Audit and Effectiveness Group (CAG) to assess audit methodology, quality, outcomes and learning in its services.

8.28 Care UK told us that prior to the CAG being set up in July 2015 audit schedules and methodology for primary care was reviewed on an annual basis *“through the dedicated engagement of key individuals from clinical, governance, medical and operational roles in*

each service stream”.

8.29 Care UK told us that services are required to submit their clinical audits on a monthly basis to the clinical audit manager who reviews them and follows up on the actions and learning arising from any partial or non-compliant clinical audits.

8.30 The governance manager told us that the CAG had decided that the UCC should audit documentation and x-rays more frequently than six monthly because of the number of patients attending the UCC.

8.31 We talked to the managing director of primary care about managing challenging, high-risk sites. She told us that Ealing had always been difficult to run because it was an unscheduled care service in a hospital environment *“competing for elective and emergency space”*. She also explained that Care UK had underestimated the complexity of the demographics of the population the UCC serves at the time they bid for the services. Many patients did not speak English. She reflected:

“One of the benefits of having such a large organisation as Care UK is we have a real suite of experts that we use predominantly to support services which are mobilising, and I didn’t actively direct them enough to wrap their arms around Ealing on an ongoing basis and say ‘We realise this is a really difficult service; we’re in it until the end. What can we do for you?’...

... if I have a similarly troubled service, I will be thinking about calling on wider resources rather than setting it up and then waiting to be notified by exception, which is what we did...”

8.32 The current regional director for the London reflected on what lessons had been learned from the allegations:

“I think it’s that balance ... between the hard intelligence that comes through in the governance report, and the softer intelligence that we pick up through listening to people, coming on site and triangulating it, if you like, and how do you do that across where you have multiple sites ... So that’s probably our last biggest lesson...”

Comment

Management and governance in Care UK is complex. This is unsurprising given the complex range and geographical spread of its services. There is however a clear line of accountability for governance from services up to the healthcare governance, risk and compliance committee and it is clear that quality and safety is discussed in a number of forums at all levels in the organisation. Care UK medical directors present their governance reports to the healthcare board.

The dashboard RAG rating format of the integrated governance report focuses on compliance and exceptions. Care UK directors acknowledged that too much focus might have been put on exceptions and that this needs to be combined with softer information about services, especially when managing difficult services.

The new governance structure is robust. Bringing governance managers closer to the services they are responsible for has clearly benefited the UCC. The governance manager has had a positive impact on governance at the UCC, including encouraging all incidents and complaints to be recorded on Datix and strengthening local governance meetings.

We highlighted in section 6 some deficiencies in the audits the UCC conducts and here make a recommendation for the Care UK CAG.

Recommendation

R23 The Care UK Clinical Audit and Effectiveness Group (CAG) should consider reviewing the types, methodology and quality of audits that take place in the UCC to ensure they provide an appropriate level of assurance regarding the quality of care provided.

Incidents

National policy

8.33 The NHS *Serious incident framework* (2015) describes serious incidents:

“The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved.”

8.34 The National Patient Safety Agency (NPSA)¹ defines a near miss as *“any patient safety incident that had the potential to harm but was prevented, resulting in no harm to patients receiving NHS-funded healthcare”* (2004).

8.35 The NHS framework describes situations where a near miss may be classified as a serious incident in cases where *“the outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. Deciding whether or not a ‘near miss’ should be classified as a serious incident should therefore be based on an assessment of risk that considers:*

- The likelihood of the incident occurring again if current systems/process remain unchanged; and*
- The potential for harm to staff, patients, and the organisation should the incident occur again.”*

8.36 The framework stipulates that the provider must report serious incidents to commissioners on the strategic executive information system (STEIS) within two working days. The provider should also have *Quality assurance processes to ensure completion of*

¹ The NPSA no longer exists but its guidance is still followed by the NHS.

high quality investigation reports and action plans to enable timely learning and closure of investigations and to prevent recurrence.” It goes on to say that providers should have “Mechanisms to ensure that actions from action plans are monitored until implemented” and should be able to demonstrate that actions have “resulted in the practice / system improvement anticipated” including “oversight of implementation by organisation leaders.”

8.37 The NHS Framework describes the role of the commissioner:

“They must assure themselves of the quality of services they have commissioned, and should hold providers to account for their responses to serious incidents. This means commissioners quality assure the robustness of their providers’ serious incident investigations and the action plan implementation undertaken by their providers. Commissioners do this by evaluating investigations and gaining assurance that the processes and outcomes of investigations include identification and implementation of improvements that will prevent recurrence of serious incidents.”

Local policy

8.38 The Care UK *Incident reporting and investigation incorporating incidents, serious incidents and accidents* (2015) policy defines serious incidents and near misses in the same terms as the national policy. It says *“all incidents and resultant action plans should be discussed at this local meeting and SIs discussed in depth”*.

What happens in practice

8.39 Any operational member of staff can report an incident on Datix. The governance manager told us that reporting via Datix had improved in the past eight months as a result of staff training. The governance manager reviews every incident reported on Datix. She told us that Care UK require a response within 72 hours. It is RAG rated and classified as a

serious incident, incident, or marked as needing to be addressed in another manner. She told us that incidents were investigated by the most appropriate manager.

8.40 If an incident is reported on Datix that those who receive a notification consider serious, a conference call takes place between the regional governance manager, the regional medical director and the clinical and managerial leads at the UCC. They aim to have this call on the day the incident is reported. They decide during the call how an incident should be classified and they assign an investigator. Serious incidents at the UCC are usually investigated by the most senior clinician in the service.

8.41 The governance manager told us that Care UK had two types of serious incidents. Reportable SIs are those that meet the national criteria and which are reported on STEIS and to the CCG. Other serious incidents that do not meet the requirements for external reporting are investigated in the same way.

8.42 She told us that an incident was classified as a near miss if there *“isn’t any harm, there isn’t any potential harm but we think there could have been”* and that it would be investigated in the same way as an SI, using root cause analysis.

8.43 The medical director for primary care, told us she reviewed all serious incident RCA reports. She also explained that a new governance support role member of staff in Care UK would keep a log of SI actions and ask for evidence from services that actions had been implemented.

8.44 We were sent an Ealing UCC Serious Adverse Event/Serious Incident log that records five serious incidents and near misses between November 2014 and September 2015. Discussions take place about serious incidents and near misses, themes, actions and implementation at the joint Brent and Ealing clinical governance meetings. Adverse events or incidents are not discussed in this forum.

8.45 The director of quality, nursing and patient safety CWHHE CCGs commissioning collaborative told us that the CCG identified provider serious incidents from the STEIS and reviewed RCA reports before the SIs were closed. He would also expect the provider to

phone and discuss the incident with the CCG quality team. He told us he expected the CCG to be made aware at contract review meetings of all incidents, including near misses.

8.46 Serious incidents are discussed at contract review meetings but the minutes do not record any discussions about the implementation of recommendations. Near misses and incidents not serious enough to be considered SIs are not discussed. The acting managing director of the CCG told us that the implementation of recommendations is discussed at the CQGs she sits on but at times it was hard for the provider to demonstrate when recommendations have been implemented.

8.47 We discuss in section 6 a serious incident in August 2013 in which a baby died after attending the UCC and then the ED. The trust serious incident report dated 21 October 2013 included recommendations relevant to both the trust and UCC. We discuss in section 9 how a recommendation related to joint working between the ED and UCC was not implemented. Other recommendations were related to the ED and UCC ensuring that observations of vital signs were completed and documented for babies. The incident and incident report were discussed at contract review meetings with the CCG. The CCG designated nurse safeguarding children told us that she sought assurance from the ED that it had shared learning with the UCC. However, the minutes show no later discussion about whether recommendations from the SI report had been implemented.

8.48 We discuss in section 6 how the UCC instigated paediatric observation audits in response to the coroner's inquest into the baby death just under a year after the SI occurred. The CCG designated nurse for safeguarding children told us that the UCC shared the findings of their observation audit with the CCG at contract review meetings as part of their assurance that they were acting on learning from the SI. However, she was clear that each provider organisation was responsible for ensuring that actions and learning from SIs were implemented in their organisation. She told us that assurance on the progress of SIs was reported to the CCG governance team.

8.49 We discuss in section 6 a serious incident when a patient died in ED at night after a delay in assessment in the UCC. The UCC reported at the contract review meeting with the

CCG three days after the incident that “*there were no SIs for quarter 3*”. The incident was not discussed at any CCG contract review meetings thereafter.

8.50 The incident was discussed at a Care UK clinical governance meeting on 3 June 2015 and described as a “*serious incident (near miss)*”. The incident brought about changes to staffing levels and processes in the UCC at night.

8.51 The governance manager told us that in retrospect she thought the incident had been incorrectly classified as a near miss. She also told us that the incident should have been the subject of an SI conference call but was not, though that was the process at the time. We asked her whether she thought that misclassification had been an issue in the past. She thought it might. She also agreed that this could be a reason for the low number of SIs the UCC reported. She thought that staff could be reluctant to classify incidents as SIs and that clinicians would often focus on clinical outcome rather than the learning from incidents.

8.52 She told us she was now confident that incidents were being classified accurately:

“I think there’s a lot more questioning ... from myself and also from the regional medical director. We are external eyes, and because we do have a lot better sight of what is going on, and an opportunity to question more, more questions are asked.”

8.53 The CCG were not aware of this incident until we discussed it with them. The CCG was under the impression that near misses would be discussed with them at contract review meetings.

8.54 We discuss in section 7 another serious incident on 29 September 2015 in which a patient who had suffered a stroke had been inappropriately prioritised during navigation. The UCC logged this incident on Datix as a ‘near miss’ after discussion with the UCC lead GP, the medical director for primary care, the director for governance and head of operations for London. The lead GP contacted the vice chair of the CCG asking for confirmation that this classification was correct, given that it demonstrated a serious process failure because patient notes had been mixed up. The CCG assistant director of

quality improvement and clinical assurance said the incident should be graded as a serious incident referencing the 2015 NHS Serious Incident framework.

8.55 The contract review meeting in October 2015 noted:

“There were no SIs for the period under discussion. There has been one SI in October, which was originally classified as a near miss but is being reclassified as an SI following advice from the commissioner’s Quality team. [X] confirmed that a full RCA would have been carried out even if the incident had remained a near miss.”

8.56 After this incident, the vice chair of the CCG invited the CCG assistant director of quality improvement and clinical assurance to attend contract review meetings with the UCC.

8.57 The CCG desktop review (July 2015) raised concerns about the low number of incidents the UCC reported. We asked the CCG acting managing director about this:

“What all of this has done is make me look at it through a different lens and not just in relation to this contract. For me it is now even low is not necessarily an indicator of good, so there are now other questions that I would be asking around ‘Are you fully picking up all your incidents? Are you sure you are?’”

8.58 The CCG has not yet looked into the reason for the low number of SIs.

Comment

Discussions about serious incidents and near misses appear to be more robust since the current governance manager started to attend clinical governance meetings. Care UK have recently introduced a governance support staff member who will keep a log of SI actions including evidence from services that actions have been implemented. This will bring Care UK in line with best practice.

Care UK and the CCG discuss SIs at contract review meetings but the CCG does not follow up on whether recommendations are implemented and Ealing UCC is not discussed at any CQG, so the CCG is not assured that learning is embedded.

We have found no evidence that the CCG took steps to establish whether the panel recommendations in an SI report into the death of a baby after care in the UCC and ED had been implemented. We would expect such a serious incident to have warranted more intense scrutiny from the CCG. This is not in line with best practice.

Incidents that do not meet the criteria for reporting onto STEIS - such as near misses - are not discussed at contract review meetings nor included in UCC reporting to the CCG. Such incidents may be discussed by the CCG at CQGs but the UCC has no such group so the CCG is not aware of the full range of incidents occurring and being reported on at the UCC. The incident in May 2015 was classified as a near miss but it should have been recorded as a serious incident, not only because the patient died and the delayed assessment in the UCC was at least a contributory factor but also because the incident had implications for staffing levels and processes in the UCC. For these reasons, regardless of its classification, the UCC should have discussed the incident with the CCG at the contract review meeting that took place three days after the incident. This indicates at best a lack of robust process, it could indicate a lack of transparency between the UCC and CCG.

We believe that misclassification may have led to underreporting of SIs in the past. However, it appears that the new processes at Care UK for reporting incidents are more robust - as exemplified by their discussions about a recent near miss that was reclassified.

In response to our draft report in February 2016, Care UK explained that they now have an established process in place when a potential serious incident has occurred. The local manager or clinical lead will escalate to the medical director, regional director or governance lead and a potential SI call is set up within 48 hours of

the incident for review by the above team, the incident is considered against the NHS definitions of a serious incident.

CCG quality team representation at future contract review meetings will be beneficial when discussing the full range of incidents being reported by the UCC.

Recommendations

R24 The UCC should conduct within the next two months an audit of all incidents over the past two years to determine whether any were incorrectly reported and classified. The UCC and CCG should decide whether any such incidents require further investigation.

R25 The CCG should seek assurance that the UCC process of classifying and reporting incidents is robust and in line with best practice.

R26 The UCC should report to the CCG all untoward incidents (including near misses and serious incidents), action plans and evidence of implementation. These should be discussed at contract review meetings with immediate effect.

Learning from complaints, serious incidents and patient experience data

National policy

8.59 The NHS Serious Incident framework (2015) explains that providers are required to have *“Mechanisms and effective communication channels to facilitate the sharing of lessons learned across the organisation and more widely where required.”*

8.60 The Parliamentary and Health Service Ombudsman published *Principles of complaint handling* in 2009, outlining six broad principles expected of public bodies. One of the principles is *“seeking continuous improvement”* -

- *“Using all feedback and the lessons learnt from complaints to improve service design and delivery.*
- *Having systems in place to record, analyse and report on the learning from complaints.*
- *Regularly reviewing the lessons to be learnt from complaints...”*

8.61 The Department of Health guidance *National quality requirements in the delivery of out-of-hours services* (2006) says:

“Providers must regularly audit a random sample of patients’ experiences of the service (for example 1 per cent per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting PCT ... Useful as questionnaires and focus groups and other methods of sampling experience may be for exploring patients’ firsthand experience of the services they have used, none create the transformational opportunities presented by involving members of the public directly in the decision-making processes at the heart of the service.”

Local policy

8.62 The *Incident reporting and investigation incorporating incidents, serious incidents and accidents* (2015) policy says learning from incidents should be shared both within the local service and in the wider Care UK Health Care Division to minimise the chance of recurrence. It sets out a number of methods for sharing learning within Care UK, including use of the Care UK shared learning tool. The policy states that regional governance manager should complete this for serious incidents and other incidents, complaints and claims. Includes anonymised details of the incident and any learning or actions. This is sent to other governance managers in Care UK who share it with those in their services. The guidance says *“on receipt local services should review and act upon the learning as necessary and any actions noted at the local quality assurance meeting”*

8.63 The Care UK, *Compliments, concerns and complaints policy* (2015) describes how complaints key performance metrics are collected, collated, analysed and monitored, providing information about “*the incidence and nature of factors giving rise to complaints*” which will be “*the basis on which improvement measures, policy, staff guidance, training materials and other resourcing requirements aimed at reducing the number of complaints will be developed.*” It goes on:

“Complaints, concerns, and compliments are an invaluable source of feedback for Care UK. They provide an audit trail and can be an early warning of failures in service delivery. Care UK is committed to continuously improving services and will ensure that learning is shared anonymously across divisions of Care UK.”

What happens in practice

8.64 Care UK uses Datix to record and report all incidents and complaints at the UCC.

8.65 The UCC started using the Datix complaints module in June 2015 to report and record complaints. Before that, complaints were recorded on a manual spreadsheet and relevant documentation saved in individual named folders. The governance manager explained that Datix allowed the governance team to see all UCC complaints in ‘*real time*’ so that they could track and run trend reports.

8.66 Locally at the UCC, learning is also disseminated at fortnightly teaching sessions.

8.67 A UCC GP told us that if a complaint was received about a GP, the lead GP discussed the response with the GP. He said the outcome and learning from significant events were emailed to all UCC staff.

8.68 The UCC collates patient survey data and friends and family scores. The Care UK action plan produced in response to the allegations included an action that the lead administrator would conduct a monthly audit of patient survey forms and feedback any

comments to the team. Results from the patient survey are discussed at the clinical governance meetings.

8.69 The UCC has recently introduced ‘*you said - we did*’ posters - which explain what people told them when patient survey data was collected and what the UCC did in response. The action plan says these posters are produced monthly after the lead administrator’s audit.

8.70 A UCC GP told us that patient experience data was not disseminated unless the result was a change to processes - in which case it would be circulated via email.

8.71 The medical director for primary care explained how learning from serious incidents was disseminated:

“It can be discussed at my monthly regional medical directors’ meetings, so today we discussed a couple of incidents that ... I feel very much hold resonance for every single service line, and we discussed what we can do to stop it happening in our own service lines. [The medical directors] will then go back to their direct line reports... and say ‘Do you know what, this could happen, and I expect to see you doing this now because of it’.”

8.72 Learning is also disseminated via the quarterly Care UK magazine ‘*Reflect*’, which includes specific incidents/accidents and learning from services across the whole of Care UK and is emailed to every Care UK employee.

8.73 The friends and family score is part of the integrated governance report, when we met with her the governance manager told us that the UCC was scoring at about 83 per cent, which is below the Care UK threshold for the metric to be green. She later confirmed that in 2015 the monthly scores ranged between 86 and 90 per cent “*which is recognised as a good score for the challenging environment*”.

8.74 Ten of 20 people surveyed by Healthwatch Ealing said they would recommend UCC to family and friends. Four rated their experience as “*very poor*” and five as “*fairly poor*”.

8.75 Care UK told us that the governance managers share patient survey data with other services via governance, risk and compliance committee and through the regional directors.

8.76 The medical director for primary care told us patient experience data was not used to share learning across the organisation.

8.77 Complaints, serious incidents and patient experience are standing items on contract review meeting agenda. For complaints, this involves a discussion about the numbers of complaints, sometimes themes (e.g. wait time) and whether any are still open but the minutes do not describe conversations about specific complaints nor about learning.

8.78 Care UK told us that the shared learning tool is only completed for serious incidents not for incidents and complaints. Care UK have sent us an email dated 31 December 2015 that the governance manager sent to clinicians at the UCC attaching five shared learning tools from SIs.

Comment

The UCC communicates learning from incidents and complaints effectively through a variety of methods. This has not always been the case for patient experience feedback but recent improvements have included audit of patient survey information, feedback to staff and posters setting out changes in the UCC in response to patient comments. This benefits patients and staff.

Learning from SIs is disseminated throughout Care UK via the Reflect newsletter and the medical director for primary care told us that she cascades learning to services via regional medical directors.

Although patient survey statistics are shared across Care UK the learning from statistics is not extracted and disseminated.

We have seen some evidence that Care UK have started to use their shared learning tool to disseminate learning from SIs and believe this tool could be used throughout the organisation for any incident, complaint or claim that has lessons that could be applied to other services.

Safeguarding

National policy

8.79 *Right care, right place, first time? Joint statement on the urgent and emergency care of children and young people* (CEM, RCGP, RCN, RCPCH, Dec 2011), under “Child protection and safeguarding” says:

“All staff ... should be trained in how to recognise and act on suspected child abuse or neglect ... there must be easy secure access, both in and out-of-hours to local authority child protection status information either electronically or through robust, swift and regularly audited processes ... to assess all children for risk irrespective as to whether they are already recorded with concerns.”

8.80 An intercollegiate document *Safeguarding children and young people competencies for health care staff* (2014) sets out requirements for safeguarding children training. It is published by the Royal College of Paediatrics and Child Health on behalf of a number of contributing professional organisations.

8.81 The Care Act 2014 set out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

Local policy

8.82 *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse* (2011) is a regional document that invites users to adapt to local needs. The introduction explains that the procedures aim to make sure that:

- the needs and interests of adults at risk are always respected and upheld;
- the human rights of adults at risk are respected and upheld;
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse; and
- all decisions and actions are taken in line with the Mental Capacity Act 2005.

8.83 The document sets out the common pan-London Safeguarding Adults policy covering definitions; considerations; referrals and safeguarding; other organisations responsibilities; commissioning and support for those involved in the process.

8.84 Care UK have a safeguarding children policy document (dated May 2015) and a safeguarding adult policy document (dated November 2015) as well as referral pathways. The UCC SOP list shows that SOP19, 'how to check vulnerable child register' has not been written.

What happens in practice

8.85 The Care UK Safeguarding Children Annual Review for Ealing UCC (September 2015) sets out some UCC statistics: the UCC refers approximately 150-200 children a month to the paediatric health visitor liaison nurse and in 2014-2015 referred approximately 120 children to Social Services. The UCC were not involved in any child focused serious case reviews/other reviews from April 2014 - March 2015 however the Care UK Annual Safeguarding Children review includes actions taken in response to a case the previous year.

8.86 The safeguarding lead for Brent and Ealing UCC left their post in September 2015. There are now two leads - one nurse and one doctor - who work across both adult and child safeguarding at Ealing UCC only (Brent is covered under a separate arrangement).

8.87 The service manager at the UCC explained that until recently the local authority provided an updated list of children subject to a child protection plan to the UCC which was printed out every Friday. She said the old process involved manually checking the paper CP list for every child once they had been booked in at the UCC. Another member of administrative staff checked the list of children attending the UCC again against the CP list later the same day to ensure that no children had been missed. The following day, a clinician reviewed the clinical notes to ensure that all appropriate health visitor referrals had been made.

8.88 The service manager told us that the UCC now has an electronic mechanism for adding a 'special patient note' onto the Adastral record for children on the register without the need to do a manual check. This immediately highlights to clinicians children on the CP list.

8.89 Changes to the list can be tracked with Excel and mapped onto the Adastral system, keeping it up to date. The October 2015 contract review meeting minutes noted that manual uploading of Ealing safeguarding data to Adastral would be completed by 11 October 2015.

8.90 The designated nurse for safeguarding children at Ealing CCG told us that a national Child Protection Information System (CPIS) was being introduced in England, with plans for all unscheduled care providers to link to it by 2018. However, in commissioning future services, Ealing CCG will stipulate that providers must be able to link to the system as soon as the relevant local authority has uploaded their information.

8.91 The child protection lists are owned by the local authority. Information relating to children on child protection plans is shared with individual providers under a service level agreement and subject to mutually agreed governance arrangements between the local authority and the Provider. This also applies to the sharing of information relating to adult safeguarding alerts.

8.92 A health visitor from the paediatric liaison health visiting service (London North West Health Care NHS Trust) reviews weekly the records of every child presenting to the UCC. This included reviews of referrals to the health visitor team, and one-to-one feedback to clinicians where safeguarding concerns had been missed. This review by the liaison health visiting services forms part of the formal communication process to “universal” health visiting and school nursing teams.

8.93 The Care UK/ Ealing UCC Joint Service Review report for 9 October 2015 says: *“Weekly meetings with HV: weekly cases discussed, lessons shared and actions immediately completed if any clinicians involved. Audit shows no clinical referrals have been missed.”*

8.94 Records from four of these weekly ‘safety net’ meetings held between 8 September and 6 October 2015 document the total number of cases reviewed and the number of cases not referred to social services or a health visitor when they should have been, as follows:

- Week 1; six cases; two not referred
- Week 2; five cases; five not referred
- Week 3; four cases; two not referred
- Week 4; six cases; four not referred

8.95 The records list the cases for discussion; date of attendance at the UCC; diagnosis/ action taken at the time of attendance; the safeguarding concern for discussion, and subsequent action plan. This included, for example, referral to social services and verbal feedback to the clinician concerned.

8.96 The CCG designated nurse said that after the change from manual to semi - automated checks, the London North West Healthcare paediatric liaison health visiting services had not identified many incidents of children with Child Protection Plans (CPPs) not being picked up by the UCC.

8.97 We have been sent safeguarding children and adult’s audits for 2015. The audits check compliance against a set of 43 standards covering practice and capability,

interdisciplinary responsibilities, policies and procedures, practice and protocols and assurance and monitoring. It allows RAG rating against each standard and action plans to address any areas for improvement.

8.98 The Care UK governance manager for London told us that these audits were being reviewed to ensure compliance with the Children Act 2004 by January 2016.

8.99 Findings of significance in the Care UK safeguarding children's UCC audit report October 2015 included:

- *"the safeguarding leads job descriptions do not yet set out safeguarding responsibilities. Written confirmation of roles and responsibilities being provided by governance manager.*
- *all substantive staff had completed the mandatory Level 3 safeguarding training. "A few" SEMP staff had not. Clinicians being chased.*
- *the GP safeguarding lead has a half a day a week designated to safeguarding duties but there is no time allocated to the nurse safeguarding lead. The action is recorded as being discussed with senior management team*
- *the UCC will be asking social services to attend health visitor liaison meetings to enhance information sharing."*

8.100 Findings of significance in the Care UK safeguarding adults UCC audit report November 2015 included:

- *"all clinical staff had received vulnerable adults safeguarding training*
- *the safeguarding vulnerable adult leads required additional training and that this would take place by the end of January 2016*
- *as of 1 November 2015 all safeguarding issues are captured on Datix and will be audited by lead GP*
- *the vulnerable adults' safeguarding lead does not interact with the local safeguarding adult board and that this would be discussed with the CCG"*

8.101 A Care UK action plan in response to the Hardcash allegations was updated in October 2015. It said that staff are completing online training to use Datix to report safeguarding incidents and that staff will be sent guidance on how to report safeguarding incidents and referrals on Datix.

8.102 The Care UK governance manager for London told us about Care UK support for the UCC in developing their safeguarding processes:

“Our director of nursing is our safeguarding lead, but in our London region we have a GP who has a special interest in safeguarding, she happens to be the medical lead for our north-west London out-of-hours service - Hillingdon, Harrow, Brent, that area. She has a special interest in it, but she is also supporting the Urgent Care Centre, both Brent and Ealing, in enabling them to change and learn and improve the safeguarding processes in the UCCs. She is meeting directly with them, looking at the LOPs and the training and the local safeguarding board meetings, and giving them some support and supervision around how their roles.”

8.103 The designated nurse for safeguarding children at Ealing CCG said she received UCC safeguarding and child protection information primarily through the contract review meetings and associated reports submitted by the UCC to the CCG. She would attend these meetings if she saw particular safeguarding issues on the agenda or in the UCC reports or meeting papers. Additionally, she would attend upon the request of the CCG contract manager or managing director. She said providers were responsible for ensuring all their staff, including locums, had the relevant training in safeguarding.

8.104 The designated adult safeguarding and clinical quality manager for Ealing CCG told us he thought the UCC might have more confidence and experience in dealing with child protection concerns than adult safeguarding, perhaps because the former UCC named safeguarding lead nurse may have had greater experience in child protection. He told us he had visited the UCC after the Hardcash programme to provide additional related support. He had suggested a number of changes to drive the adult safeguarding agenda within the UCC.

8.105 He explained that the focus on child safeguarding at the UCC reflected a national trend - historically adult safeguarding had not been as well understood or resourced as child safeguarding.

Comment

Both Care UK and the CCG have increased support to the UCC to improve safeguarding processes since the programme. UCC safeguarding lead capacity has been increased from one nurse, to one nurse and one GP lead, in line with best practice.

The old paper system for maintaining and checking child protection records was unreliable, labour intensive and posed a material risk of missing children who should be identified. It is positive that this system has recently been replaced by an automated electronic system which is an efficient and robust mechanism for identifying child protection issues.

We saw evidence that some safeguarding cases were not referred at the first opportunity when they should have been but were picked up by the safety net system.

There were some outstanding issues set out in the October and November 2015 audits associated with safeguarding systems and processes at the UCC including:

- the role and responsibilities of safeguarding leads are not yet clearly defined in their job descriptions*
- the lead nurse has not had any time allocated to perform his safeguarding duties*
- some SEMP staff have not yet completed safeguarding children training*
- the vulnerable adults' safeguarding lead does not interact with the local safeguarding adult board.*

Any issues that are still outstanding should be dealt with as a matter of priority.

As of November 2015 the UCC is using Datix to record all safeguarding referrals and incidents and this will be audited by the lead GP. This is another positive step for the UCC. Staff training to use Datix for this purpose will be key to ensuring that it is used consistently and comprehensively.

Recommendation

R27 The UCC should deal with any outstanding issues related to safeguarding systems and processes as a matter of priority.

Links with 111 and GP practices

National policy

8.106 In section 5 we set out the national context for urgent and emergency care services in the England. One of the central aims of recent national guidance being to effectively and cohesively connect the various stages and services to create a whole-system approach to treating patients. Effective links and communication between GPs, NHS 111 and urgent care centres are important for achieving this.

Local policy

8.107 One of the KPIs in the UCC contract is that 98 per cent of GPs should receive information about their patients accessing the UCC by 8am the next working day.

8.108 There is no SOP explaining the handover of results and information about the episode of care at the UCC to the patient's GP.

8.109 NHS 111¹ is not mentioned in the contract nor have we seen any other documents related to the transfer of information from NHS 111 to the UCC.

What happens in practice

8.110 During registration of a new patient, the UCC receptionist confirms a patient's GP practice and selects it in Adastra (details of all local GP details are already in the system). When a patient is discharged, Adastra automatically sends an electronic 'post event message' (PEM) to their GP's fax. If the patient is not registered locally Adastra sends the PEM into a national fax queue. This queue is monitored by the UCC administration team who call the GP recorded for each patient to confirm the patient is registered at the practice and to confirm the practice fax number.

8.111 At a contract review meeting in September 2013 the UCC "*requested*" to move to a new system whereby the PEM would be sent directly from Adastra to the electronic system in operation at GP surgeries.

8.112 As of October 2015, all but one practice had adopted the new process. This change has taken two years. The CCG acting assistant director of unplanned care told us that the CCG had helped facilitate this transition but that it had been difficult to get the GP practices to communicate with Care UK. She thought this was because practices were at the same time also migrating to a patient information system called SystmOne.

8.113 She said that not only did all GP practices in the area now use SystmOne but so did the out-of-hours provider. The CCG are thus stipulating as part of the new procurement process for the UCC that the new provider must use a system that is "*interoperable*" with SystmOne.

¹ Nor any of its predecessor services - NHS direct, NHS24, out-of-hours.

8.114 A receptionist told us that NHS 111 referred patients to the UCC and usually (but not always) faxed the UCC the patient's details. NHS 111 sometimes told patients they would be seen within "one hour" at the UCC when this was not necessarily possible. When the patient arrived they had to go through the same registration, navigation and triage process as other patients.

8.115 Care UK told us that 111 send cases to the UCC using ITK link not via fax.

8.116 If a patient referred by 111 to the UCC did not turn up, the UCC was responsible for contacting them. If the UCC cannot get through to the patient, they inform 111.

8.117 The acting assistant director of unplanned care told us that the CCG would stipulate in subsequent procurements that UCCs, 111, out-of-hours and GP practices had "interoperable" patient information systems. She explained that this will enable each component of the urgent care system to access the same information about patients and NHS 111 and GP out-of-hours to book appointments directly at the UCC. ."

Comment

The UCC would benefit from a SOP related to communication and links with other services such as GP practices and NHS 111.

The old system of faxing PEMs to GPs was out-dated and risky because it relied on the UCC keeping GP fax numbers up to date and on GP practices to check their faxes. The new system of electronic transfer is a positive step by Care UK towards interoperability.

We were told by receptionists that current communications between 111 and the UCC are unreliable. However in response to the draft report Care UK told us that 111 send cases to the UCC using ITK. There is a difference between what we were told by Care UK and the UCC for which no explanation has been offered.

The CCGs plan for Interoperability between the UCC computer system and GP practices and NHS 111 should reduce duplication of processes and avoid patients unnecessarily repeating information, thereby improving flow through the UCC.

Staff raising concerns

National policy

8.118 The 2009 Healthcare Commission investigation into Mid Staffordshire Foundation NHS Trust¹ highlighted the lack of an open culture where staff concerns were welcomed. The Council for Healthcare Regulatory Excellence (CHRE) highlighted this lack of openness as indicative of a wider problem that needed addressing in their response² to the Department of Health consultation on the NHS constitution and whistleblowing in December 2010.

Local policy

8.119 Care UK's *Whistleblowing policy - raising concerns (2015)* sets out how Care UK staff can raise concerns about risks to the wider public, patients, service-users and staff or the organisation itself without fear of losing their job or other reprisal.

What happens in practice

8.120 All those we asked said they thought Care UK was an open and transparent organisation in which to work and said they felt able to raise concerns with their managers.

¹ http://www.midstaffspublicinquiry.com/sites/default/files/Healthcare_Commission_report_on_Mid_Staffs.pdf

² <http://www.professionalstandards.org.uk/docs/psa-library/december-2010---dh-consultation-on-nhs-constitution-and-whistleblowing.pdf?sfvrsn=0>

8.121 The UCC service manager told us that staff in the UCC knew about and understood the whistleblowing policy and had used it.

8.122 A UCC safeguarding vulnerable adults (November 2015) reports that: staff can access the whistleblowing policy on the staff intranet; that there is a poster explaining it and copy in the staff room; and there is mandatory online of training about how to use the policy.

8.123 She also explained that the staff could raise concerns via a staff survey called 'Over to you' and that managers would make changes as a result of staff feedback. We saw the 2015 action plan for the UCC, which includes areas for improvement and how improvement will be achieved.

8.124 The managing director of primary care told us that the whistleblowing policy was clearly visible on the staff notice board on the intranet and that there had been two whistleblowers in her division in three years. She had also had another three staff who had emailed her directly raising concerns with her who could have used the whistleblowing option. She told us that whistleblowing allegations were investigated externally.

8.125 Care UK directors described an anonymous message system on the staff intranet that staff can use to send anonymous messages directly to the Care UK chief executive or the managing director of the healthcare division with any concerns they might have. They would pass any concerns related to primary care to the managing director of primary care to manage. She told us that she received about one every six weeks.

8.126 She also told us that she encouraged employees to raise concerns with her when she conducted site visits:

"... we talk to the staff directly ... give them a bit of time away from their boss. I might ask to look at their core concerns, what's the most recent complaint they're having which actually has changed the patient care delivery, so you try to find a number of ways to make an assessment of if the service is being safe and well led."

Comment

Staff we spoke to said they felt able to raise concerns through their managers and thought Care UK was an open and transparent environment in which staff were encouraged to raise any concerns.

There are also multiple routes within Care UK for staff to raise concerns should they feel unable to use the normal channels including both a formal whistleblowing route and an anonymous message system. We were told that staff use these routes.

9. The relationship between the UCC and Ealing Hospital emergency department

9.1 In this section we discuss the quality and effectiveness of pathways and communication flows between the UCC and Ealing hospital emergency department.

National policy

9.2 The NHS England guidance *Safer faster better: good practice in delivering urgent and emergency care* (2015) recommends:

“Where UCCs are co-located with emergency departments, it is essential that there is appropriate integration, with shared governance arrangements and clearly defined protocols for the two-way transfer of patients. Commissioners must ensure that this requirement is embedded in contracts and effectively delivered where separate providers deliver care within an emergency centre.”

9.3 It also says:

“Commissioning levers can be used to promote collaboration and mutual support between providers. The benefits of continuity of provision and care should be considered before formal procurement exercises are contemplated.”

9.4 *Healthcare for London commissioning advice for PCTs* (2010) recommends:

“Where the urgent care centre and emergency department are not using the same information systems, processes need to be established to enable patient data to be transferred between the systems, ensuring continuity of care between the two settings...”

Systems need to be established to ensure patients are only required to repeat their registration and case history details for safety and clinical purposes, and not because data cannot be transferred between the urgent care centre and emergency department.”

9.5 It identifies the following as an enabler:

“Arrangements in place to rotate urgent care centre, emergency department and polyclinic staff to transfer skills and knowledge, and enhance professional development”

9.6 Healthcare for London guidance *A service delivery model for urgent care centres: commissioning advice for PCTs* (2010) states that:

“Within a maximum of 60 minutes of the patient arriving at the urgent care centre, a clinical decision needs to be made as to whether the patient will be treated in the centre and discharged, or whether they need to be transferred to the emergency department. This standard should ensure that, where patients are transferred, the emergency department is still able to meet the national four hour A&E target (for the time from the patient’s arrival at the centre to treatment and discharge or admission).”

Local policy

9.7 The UCC contract, when referring to the relationship and interaction with the ED, says UCC should comply with the Healthcare for London commissioning guidance document described above. It goes on:

“The provider shall put formal arrangements in place for the purposes of enabling its clinical staff to be able to access specialist support and advice. This could include from the consultants in emergency medicine without requiring patients to be

transferred to the emergency department; physicians for clinical advice and opinion; access to on-call teams etc.”

9.8 The four-hour breach rate is a KPI in the UCC contract. The percentage of UCC referrals to the ED (excluding those patients that are navigated immediately to the emergency department) that breach the four-hour ED standard must not exceed two per cent.

9.9 The UCC contract says a clinical decision, for example, treatment, discharge, necessary diagnostics undertaken and transfer, should be made within two hours of a patient’s arrival at the UCC in order that he or she can be transferred to the ED without exceeding the four-hour target.

9.10 The UCC has a Care UK process map (undated) outlining the process for transfer from UCC to ED if a patient is found to be more unwell than thought at initial assessment. This includes direct transfer of the patient to an ED triage nurse. It also a Care UK emergency transfer pathway to ED (adults and children) including what to do if the patient has cardiopulmonary arrest.

9.11 The navigation policy sets out exclusion criteria for the UCC for patients who would be treated in the ED.

9.12 The UCC provided us with a trust and Care UK joint escalation process map (undated) that sets out the escalation process if the wait in the UCC for assessment or treatment is more than 90 minutes - both ‘in hours’ and ‘out of hours’. The UCC shift lead is to contact the ED shift lead (or site manager out of hours) and confirm the waiting times in the UCC and potential ED referrals or delay. If the situation is not resolved, managers in the ED and UCC agree what to do, including any advance warning if any more potential late referrals are likely. If the wait for assessment or treatment in the UCC reaches three hours, the trust head of operations should discuss it with UCC managers.

What happens in practice

The general relationship between the UCC and ED

9.13 We talked to UCC, ED and CCG staff about the relationship between the UCC and ED and they all agreed that it had been challenging for years. Various reasons were cited for this including: the UCC being run by a private company; Care UK winning the bid to run the UCC when the trust had also bid for the work; ED concerns about a number of incidents that occurred at the outset of the contract; and the UCC acting defensively to constructive criticism from the ED.

9.14 The lead GP told us that the CCG had in the past tried to help when the UCC/ED relationship had broken down by attending joint meetings but on the whole they were left to deal with it themselves.

Comment

Staff we interviewed at the CCG, UCC and ED were all aware of strained relationships between the ED and UCC. We were told that tensions had fluctuated over time but were long standing. Change in behaviours on both sides is necessary to improve the day-to-day working relationships between the two departments.

The CCG appears to have had limited involvement in the difficult relationship between the ED and the UCC, yet it commissions both services and is therefore in a position to exert influence.

Joint UCC and ED governance and meetings

9.15 We were told by UCC, CCG and ED staff that regular meetings between the ED and UCC took place until early 2015. The lead clinicians for ED and UCC met monthly to discuss clinical cases and the lead UCC GP said that that process led to the development of good

safe patient pathways. A larger operational meeting took place every other month. There are no minutes of these meetings.

9.16 UCC staff told us that these meetings had been useful but had “*fallen by the wayside*” due to poor attendance and changes in management and structure in the trust.

9.17 They also told us that relationships had deteriorated after the joint meetings stopped taking place. The UCC general manager said:

“There were very good relations on a day-to-day basis, but then sometimes meetings are cancelled or postponed or put back and you kind of lose that togetherness; yes, you do. When you work together more you want to get along more and work and drive it through. It’s more difficult to say no to someone if you don’t have a relationship with them so I’ve always encouraged building and structuring relations.”

9.18 A UCC ED clinical assurance meeting was held on 17 September 2015, chaired by the CCG and attended by the trust, the UCC and CCG. However, no further meeting was scheduled and no meetings or actions have been circulated.

9.19 We asked both the UCC and CCG for minutes of joint meetings but none were provided.

9.20 The acting assistant director of unplanned care said:

“It was an open and honest discussion. Obviously there were challenges. What also helped was the previous week the ED consultant had spent the day or the morning in the UCC and seeing what patients would come in, what clinical things. They said if they came to ED this is what we would have done, this is how we would have dealt with this patient; see and treat, they didn’t need to be triaged, you know what needs doing, you can see that, send them straight into ED. I suppose that’s part of her experience and knowledge. The invitation then was offered to the lead clinician

in UCC to go and sit for half a morning or whatever in the ED, so there's some joint learning of what happens when patients go through to them."

9.21 The ED clinical lead said:

"I would want to see monthly clinical governance meetings set up that are not just put on the responsibility of lead clinicians such as I, but that they should be run jointly, they happen every month, and that would include complaints, pathway changes, Datix incidents, and that everybody is party to them. Also, if you are criticised for perhaps not doing it the right way that you don't take offence, and that you actually take it on board that there's a patient in the middle of the issue".

9.22 Asked about the role of the CCG in these meetings, she said:

"So I think, yes, with a new provider, or whether it's the same provider that should be being led by the commissioners to make sure that the contract they've set up and the specification they have written, perhaps, on top of this is actually being done because they are supposed to be leading this, aren't they?"

9.23 The lead GP told us that meetings had taken place between the UCC, ED and paediatrics about pathways for unwell newborn babies and children and where they should be navigated to when they attended the joint reception area. He sent us an example - minutes of a meeting in January 2013 about *"Late referrals to Paeds of asthmatic children and febrile children"*. The aim of the meeting was to agree *"navigation/referral guidance for these groups of children to ensure speed and safety of patient arriving in the paediatric emergency department"*. Actions after the meeting included increasing staff awareness through training and education.

9.24 In section 6 and 8 we discussed an SI that occurred in August 2013 in which a baby died after attending the UCC and then the ED. The trust produced a serious incident report dated 21 October 2013 and included the following recommendation:

“The panel recommends that Ealing Hospital NHS Trust paediatric A&E department and the UCC collaborate in the development of guidance and expected practice standards for use when newborn babies are admitted to either the paediatric triage area or the UCC.”

9.25 We asked the UCC about whether this recommendation had been implemented and they responded in an email dated 7 September 2015:

“We have not been approached by the Paeds department with respect to this action point (please do bear in mind this was an EHT SI not a UCC one). Following on from the SI referred to below several attempts were made to hold a meeting with Paeds to review any specific pathway issues but we were not responded to”.

Comment

The escalation and referral process maps related to referral of patients from the UCC to the ED are useful. However, the UCC and ED do not have any joint governance processes, contrary to the recommendations of Healthcare for London to PCTs commissioning urgent care services. We expect they would share audits and clinical guidelines. Such policies are important in establishing continuity of care, consistency in approach and continued learning and improvement.

We heard that the regular UCC/ED meetings ‘fell by the wayside’ rather than having been stopped. Staff at the UCC told us that relationships seemed to deteriorate after the cross-departmental meetings stopped. The lead ED clinician described a joint governance meeting chaired by the CCG on 17 September 2015 as helpful, but the absence of minutes or follow-up actions resulted in the motivation for future meetings being questioned.

The re-establishment of regular effective meetings will be crucial to improving working relationships. Clear terms of reference for the meetings, a strong chair and a defined remit will be necessary to bring about change and support joint working. We would

expect the meetings to be held monthly, minuted with specific action plans and covering key topics such as: patient flows, handover issues, capacity and demand, shared audits, shared clinical guidelines, significant events and serious untoward incidents and complaints.

We saw minutes of a previous meeting between the UCC, ED and paediatrics about referral pathways to paediatrics but no evidence that such a meeting happened after the SI report of 21 October 2013. It is a source of concern that the recommendation of that SI panel report has not been implemented. This indicates poor governance and suggests low collaboration and communication between departments.

Recommendations

R28 The CCG should ensure that terms of reference are agreed for joint ED/UCC governance meetings and that the meetings are minuted and take place monthly. Someone senior from the CCG should attend at the outset to facilitate meetings.

R29 The CCG should ensure within two months that the UCC and ED collaborate to develop guidance and expected practice standards for use when newborn babies are admitted to either the paediatric triage area or the UCC.

Referrals

9.26 UCC and ED interviewees described friction between the two departments related to the navigation process. ED consultants sometimes disagree with decisions to navigate patients to the ED.

9.27 UCC staff alleged that some ED consultants challenged the navigator in an inappropriate and confrontational manner.

9.28 The ED service manager had a different opinion about such situations. She told us that ED consultants would explain to the navigator that they thought a patient should not have been navigated to the ED and the navigator would act defensively. The next day the UCC would send an email accusing the consultant of being threatening. She acknowledged that this could be true for some of the “*more fiery*” ED consultants but was not for others.

9.29 She went on to explain that she had approached the UCC about resolving the problem and had suggested that they look together at how navigation could be improved through training. She told us that the UCC had responded negatively to this because their viewpoint was that every navigator is different and makes different decisions.

9.30 The lead ED clinician told us that she had had concerns over the years about many of the patients that had been transferred from the UCC to the ED both because of “*clinical management*” and “*pathway management*” (late referral to the ED). She explained that in the past she had raised concerns with the lead GP at the UCC but now resorted to reporting incidents on Datix. She told us she had also raised these concerns with the CCG and senior management at her trust.

9.31 We were told by ED, UCC and CCG managers that late referrals (more than two hours after a patient arrives) from UCC to ED had been a long-standing issue and had been consistently discussed in the contract review meetings for the past few years.

9.32 Two KPIs relate to this issue:

- *Number of UCS referrals to ED that breach the max 4 hour wait standard for A&E* - should be less than 2 per cent
- *Access to specialist referral to acute hospital specialists (including ED) within 120 mins* - should be more than 90 per cent

9.33 The UCC consistently underperforms on these KPIs. The figures for the first KPI are taken directly from the A&E Symphony system. The UCC disputes these figures because they cannot be amended after UCC breach analysis. The contract review meeting minutes in July 2015 record:

“[The general manager] added that he believes the figures from ED count both ED and specialty referrals, when they should only be counting ED referrals. His analysis on late referrals showed that the majority are cases for specialty rather than ED.”

9.34 The ED service manager told us that the majority of ED breaches were because of late referrals from the UCC and that after three in the afternoon the UCC would start to transfer patients who had been in the UCC for “generally over three hours” and often “three hours 45/50/55, a minute to four hours.”

9.35 The UCC cannot refer patients requiring admission directly to specialty; they must be referred via the ED.

9.36 UCC managers told us most late referrals were actually referrals to a specialty not to the ED. The UCC service manager said:

“What has been the case is that, because the specialty cases get sent to ED to be picked up by specialty, they have been clocked as ED patients and, therefore, they have been reported as late referrals.”

9.37 Trust staff told us that the ED was the most appropriate waiting place for patients who needed a specialty. In the May 2015 contract review meetings UCC managers described a meeting between the trust and UCC in which they had discussed specialty pathways: “the consensus at the meeting was that the UCC isn’t the right setting for specialty assessments, and clinicians in the hospital would need to make a decision if this was going to be changed”.

9.38 An Ealing hospital consultant explained why patients referred from the UCC to specialty were sent first to ED:

“We don’t have a ward of empty beds with nurses waiting for patients to come in... The safe place for them to go is to track through the emergency department

route or straight into the medical admissions unit if there is a bed available in that unit”

9.39 Contract review minutes from September 2015 record a discussion about late referral analysis that the UCC had undertaken for April to August 2015. The analysis for each month set out the numbers of late referrals to the ED and specialty, the reasons for late referrals and any actions to mitigate. Actions included ensuring that induction for new assessment nurses included awareness of referral criteria and pathways and that all staff “*have been given in-depth training one day training, dedicated to procedures, pathways as well as management techniques*”. The action plan remained the same for each month and there was no marked improvement.

Comment

Despite the UCC having a clear navigation policy, navigation from the UCC to the ED has caused friction between the two departments. ED consultants regularly tell the navigator that sending a patient to the ED was inappropriate. We heard different views about this situation; the UCC described ED staff as aggressive and the ED described UCC staff as defensive. It is not uncommon for interpersonal relationships to become strained in high-pressure situations such as arise in urgent and emergency care settings.

National policy sets the standard that decisions to transfer to specialty (including the ED) should take place within one hour. The current contract stipulates two hours and even this target has proved difficult for the UCC to meet.

The joint trust and Care UK escalation process map sets out the escalation process if the wait in the UCC for assessment or treatment is more than 90 minutes - both ‘in hours’ and ‘out of hours’. However, the ED service manager told us that the ED regularly received patients who had already been waiting between three and four hours, so it seems the process is not entirely effective. By the time the wait in the UCC is 90 minutes for assessment or treatment, the number of late referrals to the ED (over

two hours) is likely to be high and difficult to manage. If the trigger time was shorter - for example one hour - the escalation process might be better at tackling the problem before it became too big.

The process for referring patients from UCC to specialties via the ED adds delays, duplicates effort and creates additional traffic in the ED. We heard that the reason for the pathway was that the ED was the safest place for a patient to be waiting pending assessment by specialty because there is no alternative such as a medical admissions assessment unit on the trust site. However, we think the only patients who should need to go via the ED are those needing emergency interventions and stabilisation of symptoms before being admitted to the ward.

Recommendations

R30 The CCG should work with Ealing Hospital and the UCC to explore whether it is possible to streamline the pathway for referral of patients from the UCC to specialist services.

R31 The CCG should consider stipulating in the new contract that patients who need to transfer from the UCC to the ED (not those being transferred to specialty) are transferred within one hour.

Different IT systems

9.40 The ED and UCC reception areas are co-located. However, the ED and UCC use two separate IT systems. The UCC uses Adastra, the ED and the rest of Ealing hospital uses the Cerner system. These systems are not connected and do not allow patient data to be transferred. Neither department can see the activity in the other.

9.41 The ED service manager said:

“If we were able to look at their screen, they could look at ours. If they could see that it’s chaos in there, we should probably think twice about what we’re sending. Likewise if, for example, they start off very busy and we’re okay, maybe say should we run down through the list and try and pull out the ED ones quickly now, rather than waiting, because we’ll have them coming through LAS as well, and maybe try to pull them out.”

9.42 The lead ED consultant thought the reason screens could not be shared and the UCC and ED could not access to each other’s computer systems was related to information governance because the UCC was run by a private company and that this meant the services were not transparent or integrated.

9.43 When a patient is navigated to the ED, the information handed over to the ED is limited to a one-line reason written on a UCC sheet. No electronic transfer of information takes place so patients have to repeat themselves when registering with the ED.

9.44 Similarly, when a patient is referred between the UCC and the ED no electronic transfer of information takes place. The UCC gives the ED a two-page handover.

Comment

The two departments have different IT systems but this should not be a barrier to providing cross cover and support during busy periods. The UCC and ED reception desks are co-located, so shared access to information about patient flow should be possible.

Having two separate IT systems means that the UCC and ED are not aware of levels of activity in the other. For example, the UCC usually gets busy first and then the ED receives a lot of late referrals from them - and gets busy. It would be better if receptionists could share screens so that they could see how busy the other is and plan for any surges in activity. Other UCCs, such as West Middlesex, have more integrated systems and might be models to learn from.

The inability to transfer information electronically between the UCC and ED means that information-gathering has to be duplicated, patients have to repeat their history and transfer of care and information can be fragmented.

Any barriers to transferring information or sharing access to computer systems and screens attributed to information governance could be overcome in the interests of good patient-centred care. An information sharing agreement between the UCC and the ED may help facilitate this process.

In section 7 we discuss the blanket exclusion of patients who re-attend within 30 days of being treated in hospital. The CCG explained that this happens so that the hospital can record those patients who re-attend and other statistics such as infection rates. We argue that it would be preferable for the UCC to treat those patients who are clinically suitable for the UCC and for the relevant information to be transferred to the hospital for statistical collation. A well thought-out, governed system is important for transferring information and data accurately.

Recommendation

R32 The CCG should ensure that when the new UCC contract is awarded, the UCC and ED establish processes to enable patient data to be transferred between their IT systems and consider developing a shared-screen system at reception.

Cross-departmental working

9.45 The UCC service manager thought that the lack of cross working had contributed to the poor relationship between the ED and UCC.

9.46 UCC managers told us that UCC staff were willing to work across the ED and UCC departments. Both departments welcomed an initiative for ED trainees to work in the UCC to broaden their experience but it was not implemented because of concerns about

indemnity: the ED and UCC are run by different providers. A UCC GP spoke about the opportunities for cross-working between UCC and ED clinical staff:

“It is two separate departments run by two different organisations. Certainly, some of my colleagues could do that, but I could not be an A&E physician. I don’t think that A&E doctors could be GPs.”

9.47 The ED clinical lead thought that ED and UCC doctors should undertake training and spend time in the other department and that this should be stipulated in the new UCC contract.

9.48 The ED service manager told us that the UCC and ED had tried to set up a system where the UCC could bleep ED consultant to ask them for advice and support but that it was not successful.

9.49 However a UCC GP told us he was happy to discuss any concerns he had with ED doctors and that they would give him excellent advice most of the time.

9.50 A UCC lead GP said:

“It’s not so much a problem in the day because we have a lot of staff here and we can go to our own staff, but at night the A&E registrar is a very useful person to have. If you’re not happy or you want to have a look at an x-ray, have a second opinion on a patient, the ED registrar.”

Comment

UCC and ED staff told us that different employment, indemnity and contractual issues were barriers to cross working but we think that these may not be insurmountable.

Establishing patterns of cross cover and working across both departments could improve relationships, understanding of the challenges and working together to implement agreed solutions.

Recommendations

R33 The CCG should consider, when the new UCC contract is awarded, requiring the UCC and ED to:

- set up joint educational/continuing professional development/audit sessions for ED and UCC staff to foster closer working relations and mutual understanding of competing departmental pressures.
- rotate staff in order to transfer skills, knowledge and understanding between the departments. Staff must be supported by appropriate training, induction and supervision.

10. Estates issues

10.1 Our terms of reference ask us to investigate concerns raised during the CCG clinical visit on 6 July 2015. Concerns related to layout and capacity of the urgent care centre:

- the waiting room is not visible from reception and is too small and therefore overcrowding is an issue;
- the children's waiting room is not clearly separated from the main waiting area and is too small and therefore overcrowding is an issue; and
- there is no waiting area for vulnerable adults.

10.2 We discuss these concerns and other issues raised directly with us in this section.

10.3 The issue of privacy and dignity and recommendations related to the layout of the department is discussed in section 6.

National policy

10.4 *Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings* (2012) states:

- “1. Emergency care settings accommodate the needs of children, young people and accompanying families and comply with DH You're Welcome and HBN 22 standards*
- 2. As well as audio-visual separation from adults, consideration is given to security issues, availability of food and drink, breast-feeding areas, and hygienic, safe play facilities*
- 3. At least one clinical cubicle or trolley space for every 5,000 annual child attendances is dedicated to children*
- 4. Young people have access to quieter waiting and treatment areas, and age-appropriate games, music or films”*

10.5 CEM Healthcare for London 2010:

“We expect patients to be given an estimate of the likely waiting times for assessment and treatment on arrival at the urgent care centre and to be informed if there are any significant changes to this timeframe.”

Local policy

10.6 Schedule 2 of the contract says:

“The provider shall ensure that the provision of the services and the unscheduled care centre premises protect and preserve patient dignity, privacy and confidentiality.”

What happens in practice

10.7 The main waiting area is to the far right of the reception area, outside locked double doors that lead to individual treatment and consultation rooms. The UCC waiting area was often at capacity when we visited.

10.8 The UCC has no separate waiting area for vulnerable adults. Mental health patients are expected to wait in the main waiting area or children’s waiting area and we saw this cause disruption in the UCC and drew attention from other people in the waiting room.

10.9 The children’s area is next to reception and is partitioned from the main reception area by a wall but is not fully separated. It was sometimes overcrowded on our visits. The UCC has a dedicated paediatric consultation room.

10.10 CCTV cameras project images of the waiting area that UCC staff can see on several monitors in the department, including reception. The waiting area is just visible from the navigator’s desk at reception.

10.11 We saw little written information in the waiting area for members of the public about when to attend UCC, ED or calling 111 or ambulance services. Signage about waiting times was limited to a handwritten white board behind reception. This was blank on at least one occasion when we attended.

10.12 A receptionist told us that patients often get annoyed about how long they have to wait. He thought it would be helpful to have an electronic sign that indicated the waiting times in the waiting room.

10.13 The CCG acting assistant director of unplanned care told us that the CCG had not been aware of the problems with the layout and space at the UCC before the July clinical visit:

“it was set up as part of the procurement of the UCC and what was arranged between Ealing Hospital and the PCT at the time, so that is what we have run with. We have not really questioned it in any way.”

10.14 She told us that after the department was flooded in January this year, the CCG conducted a ‘walk round’ to ensure that the department was fit for purpose and ready to accept patients. She went on:

“Going forward ... the contract is coming up for renewal and it is obviously an opportune time for us to review the space and the location and how that is then configured and laid out, including those issues around the privacy.”

10.15 Care UK told us that Care UK Buildings experts had raised the issue of the inadequacy of the physical space in the UCC with the CCG pre-procurement, post award and at several points during the first 18 months of operation. We have seen no other evidence to support this assertion.

Comment

The waiting area is not big enough for number of patients who attend the UCC, the waiting room for children is not sufficiently separated from the main waiting area and the present layout does not meet the privacy requirements of vulnerable adults.

Information about waiting times is not well displayed and not kept up to date. Clear signs telling patients about the most appropriate use of emergency, unscheduled and primary care services could better support the CCG's strategic objectives of reducing inappropriate UCC attendances.

Recommendations

R34 The CCG should consider ways to improve privacy at the front desk and for children and vulnerable adults in the waiting room in line with national good practice.

Team biographies

Jess Heinemann

Jess has worked at Verita since 2011. As a consultant she has worked on a number of high-profile cases. She was a member of the team providing national oversight and assurance to investigations into allegations about sexual abuse by Jimmy Savile in healthcare, educational and social care settings. Other cases include a review of a specialist paediatric service in the north of England, a governance review of a leading private healthcare provider, two investigations into practice and reporting in emergency departments and a review of GP performance issues. Jess has recently completed the John Hopkins University Science of Safety in Healthcare course.

Stephanie Bown

Stephanie Bown is a highly experienced medico-legal specialist. She is a registered medical practitioner and an accredited mediator with a law degree. She is a former senior executive at a medical professional services membership organisation (MPS), and was director of the National Clinical Assessment Service for a year before joining Verita in May 2015.

Stephanie has a deep understanding of the legal and regulatory framework applying to healthcare combined with political awareness and a thorough, analytical and evidence-based approach to investigation and reviews. Her experience includes successfully representing senior clinicians through investigations into their professional practice and handling complex, sensitive and emotionally charged investigations and the ensuing media attention.

Barry Morris

Barry joined Verita soon after it started in 2002. He has a wide range of experience in investigations and reviews. He is currently working with Lucy Scott-Moncrieff on her quality assurance of the Department for Education Savile investigations and her “lessons learnt” report, and he has just completed work leading the sampling team supporting Kate Lampard in her oversight of the NHS investigations into matters relating to Jimmy Savile. Recent work, commissioned by Dr Mike Bewick, deputy medical director for NHS England, includes a high-profile investigation into paediatric cardiac surgery in Leeds Teaching Hospitals NHS Trust after concerns were raised by another NHS trust, and a governance review of the obstetrics and gynaecology department at South London Healthcare NHS Trust in the light of concerns about a consultant there.

Barry previously worked as a consultant in financial and general management where he specialised in working with companies and charities in change management, organisational development and finance. He is a trustee of PAC-UK, a charity based in London and Leeds working in the field of adoption.

Mark Spencer

Dr Mark Spencer has been a doctor in the NHS for 30 years and a GP principal in Fleetwood since 1991. He was elected as clinical lead and chair for Fleetwood CCG in 2009, a position he held until the merger of the CCG in 2012. He was appointed as clinical lead for service integration for Blackpool Teaching Hospitals NHS Foundation Trust in April 2013 where he was responsible for the delivery of QUIPP initiative around urgent care and community service. He is the co-founder and director of Fylde Coast Medical Services, a social enterprise that provides out of hospital urgent care services including urgent care centres, out of hours GP services and 111 call taking services across the Fylde Coast and North West England. He sat on the Department of Health advisory board for the development of primary care out-of-hours services.

Mandy Rumley-Buss

Mandy is an experienced emergency and urgent care nurse with over 30 years' experience and has spent the last two years working in interim management roles in failing emergency care and acute medicine settings. She maintains a clinical role in a local Urgent care centre. She has recently been appointed as a clinical adviser to the new Emergency Care Improvement Programme (ECIP) which has been set up by the DH, Monitor, TDA and NHS England to help the most challenged urgent care systems to provide better, faster, safer care for patients.

She works with NHS elect within the Acute Frailty Network as an adviser and in supporting service improvements across six sites in England. In 2007 she worked in the PCT urgent and emergency care programme which set and monitored provider KPIs and performance. Between 1999 and 2013 she was a Department of Health approved nurse consultant working in Urgent and Emergency care settings.

She is a steering group member of the Royal College of Nursing Emergency Care Association and has taken a lead on Ambulatory care and urgent care initiatives. She was involved in the development of the Silver book, BEST staffing tool and is currently developing RCN competency tools for Accident and Emergency care.

Terms of reference

Terms of Reference for an Independent Review into Care UK Ealing Urgent Care Centre (UCC): July 2015

Purpose of the Independent Review:

The purpose of this Independent and high level review is to identify any clinical risks in the provision of services by Care UK Ealing UCC. It will focus on key lines of enquiry as subsequently outlined.

Membership:

- A General Practitioner with experience and expertise in Urgent Care
- A Nurse Practitioner with expertise in Emergency Care
- A Commissioner
- A lay member or an Independent Healthwatch to comment on the results of the review.

Governance:

- This review forms part of the assurance process of NHS Ealing CCG into the quality of the services provided by Care UK Ealing UCC.
- The results of this review will be reported to NHS Ealing CCG's Quality and Patients Safety Committee, Ealing Healthwatch and NHS Ealing CCG's Governing Body
- In addition the independent review report will be submitted to NHS England for STEIS number 2015/23485 and will fulfil the root cause analysis requirements for a serious incident.

Key Lines of Enquiry (KLOE):

- To evaluate the service against the service specification as outlined in the contract and against best practice guidelines for UCC's
- To measure the quality, impact and effectiveness of internal Care UK governance processes, including Board Assurance processes for quality and patient safety.
- To measure the quality, impact and effectiveness of Commissioner Assurance processes, including assurance processes for quality and patient safety.
- To evaluate processes for learning from and disseminating learning from complaints, Serious Incidents, PAL's enquiries, the Friends and Family Test and other mandated patient experience data gather over twelve months to June 2015.
- To investigate the areas of concern raised by the Hardcash documentary film (appendix 1), from the Clinical Visit (appendix 2) and from the desk-top review (appendix 3) with the purpose of understanding actions required to prevent recurrence.
- To review the patient journey from registration to discharge or transfer and onward communication.
- To review quality and effectiveness of the pathways and communication flows between the UCC and the Emergency Department.
- To understand the barriers (if any) to safe and effective care for patients and propose remedial action where appropriate.

Appendices available on request:

1. Letter from Hardcash Productions to Chief Executive, Care UK dated: 22.06.2015
2. Report from Clinical Visit by Drs. Webster and Hakim on: 06.07.2015 by
3. Briefing informing of the Desktop Review dated: 07.07.2015
4. NHS England (London) Assurance Report - concerning the issues raised at Ealing Urgent Care Centre:
[NHS England (London) Initial Clinical Review- Ealing Urgent Care Centre]

Actions taken in response to NHS England suggested areas of focus

NHS England suggested areas of focus	Verita response
<p>NHS England (London) recommends that the review ensures that all staff working in the UCC are up to date with the required mandatory pre-employment checks including;</p> <ul style="list-style-type: none"> • Mandatory qualifications and training • Recording of the relevant responsible officer • Disclosing and Barring Service checks • Appropriate checks against the GMC and NHS England performers lists status <p>Qualifications for all Doctors and NMC status for Nurses</p>	<p>We have reviewed training logs for all staff and have highlighted any gaps in our report and have made recommendations. It is not within our remit to ensure all staff are up to date. This was agreed with the CCG.</p> <p>We asked Care UK for record of:</p> <ul style="list-style-type: none"> • Recording of the relevant responsible officer • DBS • Checks against GMC and NHS England performers list • Qualifications for all doctors and NMC status for nurses <p>NMC/GMC, indemnity, DBS recorded in compliance log for all substantive NEPs, nurses and GPs and SEMP</p> <p>Care UK informed us that the responsible officer in Care UK is Dr Rob Loveland, the medical director for secondary care. He will only be the RO for substantively employed GPs. This is not recorded for GPs.</p> <p>Care UK did not provide us with a record of checks against the NHS England performers list nor doctors qualifications.</p>

<p>NHS England (London) recommends that the review provides assurance that all staff are up to date with required mandatory training including, but not exclusive to:</p> <p>Evidence of successful completion of required training of health professionals working in the UCC (including the GP urgent skills course)</p> <p>Child and Adult safeguarding training</p>	<p>We have reviewed training logs for all staff, highlighted any gaps and made recommendations in the report. The urgent skills course ran once and is not a mandatory requirement for UCC GPs and NEPs.</p> <p>It is not within our remit to ensure all staff are up to date. This was agreed with the CCG.</p>
<p>NHS England (London) recommends that Ealing CCG review the content of the GP urgent skills course and ensure it is in line with best practice</p>	<p>We have asked for this course content but it has not been provided to us.</p>
<p>NHS England (London) recommends that Ealing CCG reviews staffing establishment across different professional groups (as minimum, across medical, nursing and HCA) to identify current position and trends regarding whether these are safe and in line with contract requirements. As a minimum this should include:</p> <ul style="list-style-type: none"> Funded staffing establishment - WTE established staffing 	<p>The issue of understaffing has been reviewed and findings are set out in the report.</p> <p>We have not reviewed the sickness and unscheduled absences- absence rates by staff group as they have not been raised as particular issues at interview. This was agreed with the CCG.</p> <p>A number of additional points raised by NHS England have been checked with our clinical advisers, are set out below but have not been included in the report.</p> <ol style="list-style-type: none"> Agency usage

<p>breakdown by staff group</p> <ul style="list-style-type: none"> • Number of vacancies - vacancy rate by staff group • Sickness and unscheduled absences- absence rates by staff group • Use of bank and agency staff - Percentage daily bank and agency rate and the number of shift sessions by staffing group • Daily staffing fill rate against planned requirements, by staff group • The duration taken to recruit medical and nursing staff to vacant positions and if this exposes the service to risk 	<p>Agency usage for 3 months (chosen by us at random):</p> <table border="1" data-bbox="703 394 1062 604"> <tr> <th></th><th>Agency Usage</th></tr> <tr> <td>Sept 14</td><td>30.29%</td></tr> <tr> <td>Jan 15</td><td>40.23%</td></tr> <tr> <td>May 15</td><td>33.68%</td></tr> </table> <p>Our clinical advisors feel that this high agency usage could lead to concerns regarding safety and consistency and therefore would expect managers to put additional quality and safety checks in place. They would also expect an action plan to show how they are trying to recruit more substantive staff and reduce agency usage. The CCG may want to ask for evidence, discuss and monitor this risk.</p> <p>2. Staff turnover</p> <p>UCC staff turnover for the 12 months prior to November 2015 was 34.78%. Staff groups that have left the organisation over the last 12 months include; Service Manager, Safeguarding Lead, 1 x PAYE GP, 3 X Nurse Practitioners and Lead Nurse.</p> <p>Our clinical advisors have commented that this is a high turnover rate (5-10 percent being a more acceptable level) particularly in relation to nursing staff. This combined with a high use of bank and agency means our advisers would expect Care UK to record staffing as an organisational and delivery risk with an appropriate action plan e.g. have Care UK put in place leavers interviews - are there any</p>		Agency Usage	Sept 14	30.29%	Jan 15	40.23%	May 15	33.68%
	Agency Usage								
Sept 14	30.29%								
Jan 15	40.23%								
May 15	33.68%								

	<p>themes in the reasons people are leaving? (e.g. satisfaction, concerns about safety, frustration). We do, however, acknowledge that the issue of staffing is not unique to Ealing UCC and would expect to see similar figures in other UCCs. UCCs are having difficulty getting medical staff as the same cohort of doctors are now being paid for extended GP sessions at higher pay rate and lower work load. The CCG may want to ask for evidence, discuss and monitor this risk.</p> <p>3. Duration taken to recruit medical and nursing staff to vacant positions</p> <p>No issues</p>
<p>NHS England (London) recommends that clinical and lay review should assess the effectiveness of the following and advise NHS England on the outcomes.</p> <p>Booking triage and Assessment processes</p> <p>An interim report should be provided to NHS England if any safety issues are highlighted.</p>	<p>Systems assessed, presented in interim findings to CCG and set out in report in detail including recommendations.</p>
<p>NHS England recommends that Ealing CCG should review Child and Adult safeguarding processes in the UCC and</p>	<p>Child and adult safeguarding processes reviewed and findings set out in report.</p>

ensure compliance this should include health visitor and school nursing liaison for children of concern	
NHS England (London) recommends that the process for management of results and handover of care to the patient's GP is reviewed.	The process for management of results and handover of care to the patient's GP reviewed and set out in report.
Process for ensuring that GP assessment of the X-ray is compared with the formal radiologist report and any appropriate action is taken to ensure that no fractures are missed.	This process has been reviewed and findings set out in report.
NHS England recommends that Ealing CCG seek assurance/evidence that SOPs are in place (for handover to GP and X-rays) and reviewed within the relevant timescales.	X-ray SOP reviewed and findings set out in report. No GP handover SOP - recommendation made in report.
NHS England (London) recommends that the clinical and lay review membership should include a pharmacist to review the processes of medicines management in Ealing UCC and to advice on matters of stock control.	A pharmacist was not included in our panel but we feel we have adequately reviewed the pharmacy issues and will present findings in our report. This was agreed with the CCG.

NHS England also recommend that Ealing CCG ensure that an audit is undertaken to provide assurance that up to date OOH pharmacy information is available to patients in Ealing UCC	The UCC provided us with up-to-date OOH pharmacy information and told us that it is available to patients.
NHS England (London) recommends that Ealing CCG commission a formal review of complaints. Review themes and trends in complaints and any actions required	We have reviewed the Care UK complaint policy, complaints logs and have reviewed how learning from complaints is disseminated within Care UK but we have not conducted a formal review of complaints. This was agreed with the CCG.
NHS England (London) recommends that that the Clinical and Lay review should review the process for staff to raise concerns about care and if this is understood and used by staff.	This process has been reviewed and findings set out in report.
NHS England (London) recommends that Ealing CCG assess whether any modification of the building is feasible and also that the clinical review should assess patient care in the reception area and advise NHS England of any improvements that can be made.	We have conducted observations and discussed estates issues at interviews and findings set out in report.

(In relation to the vulnerable patient identified in the Television programme NHS England has directed Ealing CCG to undertake and review of this patients care and treatment and to advise NHS England of any concerns or breach of policy)	This incident has been investigated via interviews with staff members and findings set out in report.
NHS England (London) recommends that Care UK should investigate the employment and professional issues noted and then consider whether referral of the member of staff to the regulator is appropriate.	This is a Care UK action point and not in our remit. This was agreed with the CCG.
NHS England (London) recommend that that the CCG review current contract monitoring processes and consider increasing their frequency.	We have reviewed contract monitoring processes and findings set out in report.
NHS England (London) also recommend that Ealing CCG continue to closely monitor the financial and performance position of Ealing UCC and ensure an on-going dialogue is maintained with Care UK to address any arising concerns.	This is a CCG action point and is not in our remit. This was agreed with the CCG.

Documents reviewed

Ealing CCG

- UCC audit reports, 2014-15
- UCC contract meeting papers, 2013-15
- UCC JSR reports, January 2014 - June 2015
- UCC contract, July 2011
- UCC performance reports, July 2012 - June 2015
- Navigation policy, January 2013
- Joint escalation policy
- Information around medicines management
- Ealing CCG reviews of the UCC
- Prescribing data, 2013 - 2015
- Stock list analysis
- SI investigation report, 21 October 2013
- UCC exception reports, 2014 - 2015
- UCC contract review meeting papers, September 2015 - October 2015
- Governing body meeting minutes, 2012 - 2015
- Quality and safety committee minutes, 2013 - 2015
- Integrated performance and quality reports
- Finance and performance committee terms of reference
- Management executive committee terms of reference
- Ealing CCG constitution, April 2013

Care UK

Policies and procedures

- Work experience for medical students policy, February 2012

- Whistleblowing policy - raising concerns, January 2013
- Concerns and complaints policy, May 2013
- Incident reporting and investigation incorporating incidents, serious incidents and accidents, May 2013
- Privacy, dignity and respect policy, June 2013
- Clinical audit policy, September 2013
- Work experience policy, May 2014
- X-ray reporting and recalling process, August 2014
- Ordering of medication process, November 2014
- Human resources performance and development review policy, November 2014
- Elearning modules and learning management system user guide, December 2014
- Human resources learning and development policy, February 2015
- Clinical governance policy within the healthcare division, February 2015
- Stock control process, March 2015
- Medicines management policy - primary care and secondary care services, April 2015
- Escalation process, April 2015
- Safeguarding children policy, May 2015
- Compliments, concerns and complaints policy, June 2015
- Whistleblowing policy - raising concerns, August 2015
- Safeguarding adults policy, August 2015
- Medical appraisal policy, August 2015
- Incident reporting and investigation incorporating incidents, serious incidents and accidents, September 2015
- Navigation policy, October 2015

Staff

- Organisation structure charts including the healthcare executive team, integrated governance team members across primary and secondary care and the primary care governance team
- UCC job descriptions

- Staff rotas
- DBS log
- Compliancy spreadsheet
- Recruitment process
- Training records
- Induction pack

Performance

- KPI performance reports, July 2014 - June 2015
- Case note audits
- Documentation audits
- Prescribing audits
- Paediatrics observations audits
- Medicines management audits
- X-ray audits
- Complaints log, 2014 - 2015
- Ealing incidents log, 2014 - 2015
- Ealing risk register
- Safeguarding referral log 2015
- Safeguarding vulnerable adults audits
- Safeguarding children audits
- UCC data, 2014-15
- Patient experience survey for urgent care
- Patient survey summary, July - September 2015
- *Secondary care quality account 2014-15, May 2015*

Meeting minutes

- Huddle meetings summary and actions, June - September 2015

- Brent and Ealing clinical governance meeting minutes, 2013 - 2015
- Patient forum meeting minutes, 2015
- Health visitor meeting notes, 2015
- London regional management team meeting minutes, 2014 - 2015
- Clinical audit and effectiveness group meeting notes, 2015
- Governance risk and compliance committee meeting minutes, 2015

Other

- Ealing action plan, July 2015
- X-ray guidelines
- UCC emergency transfer pathway to ED
- UCC transfer to ED
- UCC exclusion list
- Complaints process
- Safeguarding adults pathway, October 2015
- Safeguarding children pathway, October 2015
- 'Reflect primary care', Spring 2015 edition
- Front desk process
- Governance risk and compliance committee terms of reference, March 2011

Reports

- *Developing urgent and emergency care facilities and system specifications*, Healthy London Partnership
- *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse*
- *Urgent and emergency care clinical audit toolkit*, Royal College of General Practitioner

- *The code: professional standards of practice and behaviour for nurses and midwives*, Nursing and Midwifery Council
- *Seven steps to patient safety* (2004) National Patient Safety Agency
- *National quality requirements in the delivery of out-of-hours services* (2006) Department of Health
- *Clinical imaging requests from non-medically qualified professionals* (2006) Royal College of Radiologist
- *A service delivery model for urgent care centres: commissioning advice for PCTs* (2010) NHS Commissioning Support for London
- *Review of GP Out-of-Hours Services* (2010) The Regulation and Quality Improvement Authority
- *Standards for children and young people in emergency care settings* (2012) Royal College of Paediatrics and Child Health
- *Minimum security standards for the management and control of controlled drugs in the ambulance sector* (2012) NHS Protect
- *Mandatory nurse staffing levels* (2012) Royal College of Nursing
- *Urgent and emergency care - a review for NHS South of England* (2013) The King's Fund
- *Primary medical care functions delegated to clinical commissioning groups: guidance* (2014) NHS England
- *Why children die: death in infants, children and young people in the UK* (2014) Royal College of Paediatrics and Child Health and National Children's Bureau
- *Out-of-hours GP services in England* (2014) National Audit Office
- *Urgent care centres: what works best?* (2012) Primary Care Foundation
- *British guideline on the management of asthma* (2014) British Thoracic Society
- *Our new approach to the inspection of NHS GP out-of-hours services: findings from the first comprehensive inspections* (2014) CQC
- *Five year forward view* (2014) NHS England
- *CCG assurance annual assessment 2014*, (2014) NHS England
- *Primary care in emergency departments: a guide to good practice* (2015) NHS England
- *CCG assurance framework 2015/16* (2015) NHS England

- *Serious incident framework* (2015) NHS England
- *Accountability and delegation - a guide for the nursing team* (2015) Royal College of Nursing
- *Initial clinical review: Ealing Urgent Care* (2015) NHS England
- *Transforming urgent and emergency care services in England* (2015) NHS England

Other

- Correspondence between Hardcash and Care UK outlining allegations
- CWHHE CCGs commissioning collaborative's terms of reference
- The Royal College of Emergency Medicine's 'Vital signs in children' form
- The Royal College of Emergency Medicine's 'Triage position statement', April 2011
- NHS's 'Clinical assessment tool for the febrile child 0-5 years'

List of interviewees

NHS Ealing Clinical Commissioning Group

Dr Mohini Parmar, chair

Dr Raj Chandok, vice chair and GP

Tessa Sandall, acting managing director (two interviews)

Acting assistant director of unplanned care (two interviews)

Designated adult safeguarding and clinical quality manager

Designated nurse safeguarding children

Pharmacist, medicines management team

London North West Healthcare NHS Trust

Deputy divisional general manager - emergency and specialist medicine

Consultant infectious diseases physician

Consultant radiologist

Clinical lead consultant, emergency department Ealing Hospital

CWHHE CCGs Commissioning Collaborative

Jonathan Webster, director of quality, nursing and patient safety

Deputy director quality, nursing and safeguarding

Commissioning development manager

Care UK

Suzanne Lawrence, managing director for primary care

Marjorie Gillespie, medical director for primary care

Former regional director (London)
Regional director, London
Quality governance manager
Director of nursing, primary care division
Head of pharmacy
Regional medical director for London primary care
UCC service manager (two interviews)
UCC general manager
UCC lead audit GP
UCC clinical lead
UCC lead nurse
Two UCC GPs
UCC nurse practitioner
UCC paediatric consultant nurse and safeguarding lead
Two UCC receptionists

Hard Cash Productions

Richard Butchins, producer
Alice McShane, reporter