Bristol Community Health C.I.C.

1-296908348

Urgent care services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-401031903	Urgent Care Centre	Urgent Care Centre	BS14 0JZ

This report describes our judgement of the quality of care provided within this core service by Bristol Community Health C.I.C. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Bristol Community Health C.I.C. and these are brought together to inform our overall judgement of Bristol Community Health C.I.C.

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

We rated this service as good overall because:

- Staff complied with safe systems to protect people from abuse and avoidable harm. The service had a good track record on safety. There was an open culture; staff were encouraged to report concerns and incidents. Incidents were investigated and used to identify learning.
- People had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. Staff had access to a range of national guidance, local protocols and referral pathways and monitored the effectiveness of, and compliance with, processes and referral pathways.
- Staff, including those in different teams, worked together to provide seamless and coordinated care. Staff had access to remote advice and support from healthcare partners.
- Staff were suitably qualified and experienced to undertake their roles and were supported and encouraged to update and extend their skills and to develop areas of interest.
- Feedback from patients and those close to them was consistently positive. The department received overwhelmingly positive feedback from patients and this was consistent with the feedback we received during our inspection. Patients we spoke with were fulsome in their praise for staff. We heard of numerous examples where staff had “gone the extra mile” to support people.
- Staff treated patients with dignity, respect and kindness during all interactions. Patients told us that staff took time listen to them and felt supported by them.
- The urgent care centre provided a convenient and accessible service for patients who could not access primary care services and/or who may have otherwise presented at an emergency department.
- Staff took steps to support patients in vulnerable circumstances and those with complex needs.
- People’s complaints and concerns were listened to and responded to. Learning from complaints was used to improve the quality of care.
- The local leadership team was well respected, visible and accessible. Staff were inspired by and supported by a strong and cohesive leadership team.
- Staff enjoyed working in the urgent care centre. The department had experienced a difficult year, with high demand, high staff turnover and staffing shortage, including holding a management vacancy. In spite of this, morale was high, staff expressed pride in their service and they were optimistic for the future.
- There were effective governance arrangements. Information was regularly monitored to provide a holistic understanding of performance, including safety, quality and patient experience.
- Patients and the public were engaged and involved. Their views were captured and acted upon to shape and improve the service.
- There was a strong focus on learning and improvement. Audit was used to drive improvement, mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient safety and quality.

However:

- The department did not monitor or report on the time that patients waited for their initial assessment (triage). Therefore, we could not be assured that patients were always assessed promptly in order to identify or rule out life threatening conditions.
- Patients were not always able to access care and treatment in a timely way. Increasing demand and periods of under-staffing resulted in the frequent restriction of the service.
- Results from the 2016 staff survery had been mixed. There was some concerning feedback about pressure of work.

Summary of findings

Background to the service

The Bristol Community Health urgent care centre is a nurse-led walk-in medical centre to support the local community in South Bristol with urgent minor injuries and illness.

The centre is based at South Bristol Community Hospital and is open from 8am to 8pm daily. The service provides care and treatment to adults and children with minor injuries such as sprains, strains or scalds and minor illnesses. Children under two who present with a suspected fracture, which requires X-rays, will be referred to the local children's hospital immediately. The centre also provides emergency contraception.

The service is accessed by self-presenting patients, patients referred by their GP and patients brought by ambulance (subject to them meeting the acceptability criteria and pre-alerting the department of their arrival). The service has agreed exclusion criteria which identifies certain categories of patients who are not suitable for care and treatment at the urgent care centre. These include patients with life-threatening conditions, patients requiring detailed diagnostic investigations, patients with serious or multiple injuries, patients with major systemic illness and serious co-morbidities.

The urgent care centre comprises a reception and waiting area, six consultation rooms, two single treatment rooms, two double treatment rooms, a plaster room, a secure interview room, a range of clinical and store rooms, staff accommodation (offices, rest room and toilets), public toilets and baby change and breastfeeding facilities.

There were 37,415 attendances at the urgent care centre between October 2015 and September 2016, of which around 30% were children. Demand for services had increased by 26% in the year to September 2016, compared with the previous year. One of the reasons for this, cited by the organisation, was a shortage of GPs in Bristol.

We conducted an announced visit to the urgent care centre over two weekdays and returned unannounced on a Sunday. We spoke with fifteen staff in total. These included registered nurses, paramedics, health care assistants, reception and administrative staff and managers. We spoke with ten patients and one relative. We also telephoned five patients and reviewed six CQC comment cards completed by patients who visited the department in the weeks leading up to the inspection.

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken, invited independent chair

Team Leader: Alison Giles, Care Quality Commission

The team included CQC inspectors and a specialist nurse with experience in urgent care services. We were also supported by two experts by experience who talked with patients who had consented to talk with us by telephone about their views and opinions.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Good

Are services safe?

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting the service, we reviewed a range of information we hold about the organisation, asked the provider to send us a wide-range of evidence, and asked other stakeholder organisations to share what they knew. We carried out announced visits on 16 and 17 November 2016 and returned for an unannounced visit on 27 November 2016.

During the visits we met with a range of staff who worked within the services, such as nurses, healthcare assistants, receptionists, and managerial staff. We talked with people who use services. Our experts by experience telephoned a group of patients and carers who were receiving, or who had received care and support. During our visits, we took time to observe how patients were being cared for, and we talked with carers and/or family members. We reviewed treatment records and other information about people's care.

Outstanding practice

- In the urgent care centre we heard of numerous examples where staff had gone the extra mile to support patients and those close to them.
- The urgent care centre had developed a comprehensive support network and a range of referral pathways for adults and children in primary, secondary and community health care settings.
- The urgent care centre had engaged the support of the lead emergency consultant at the local children's hospital to facilitate joint working, and education.

Areas for improvement

Action the provider SHOULD take to improve

- Ensure that staffing levels and skill mix in the urgent centre are appropriate to ensure that the department is able to respond to increasing demand for the service. Frequent restriction of the service causes inconvenience, frustration and anxiety to patients and may result in patients presenting inappropriately to emergency departments.
- Continue to take steps to appoint to the position of operational lead for the urgent care centre, which has been vacant for over 10 months.

Good

Are services safe?

By safe, we mean that people are protected from abuse and avoidable harm

Good

Are services safe?

Summary

We rated this service as good because:

- The service had a good track record on safety. There was an open culture; staff were encouraged to report concerns and incidents. Incidents were investigated and used to identify learning.
- There were robust systems, processes and practices in place to protect adults and children from abuse.
- Risks to patients were assessed and appropriately managed. The department used a recognised system to prioritise patients, according to the seriousness of their condition.
- The department was staffed to its funded establishment. Staffing levels were under review in light of increased demand.
- Staff were up-to date with essential training in safety systems.
- Staff complied with safe systems in relation to the storage, prescription and administration of medicines.
- Premises and equipment were well maintained and clean. Staff complied with safe systems to prevent and protect people from healthcare-associated infection.

However:

- The department was frequently under staffed, although this was improving now that the department was staffed to its funded establishment. Systems were in place to restrict the service when safe levels of staffing were not achieved.
- The department did not monitor or report on the time that patients waited for their initial assessment (triage). Therefore we could not be assured that patients were always assessed promptly in order to identify or rule out life threatening conditions.
- Patients' records were not always complete. In particular, staff did not consistently record pain scores or consent to care and treatment.

Detailed findings

Safety performance

- The service had a good track record on incidents. There were no serious incidents or never events reported in the urgent care centre from July 2015 to July 2016.

Incident reporting, learning and improvement

- Staff understood their responsibilities to record safety incidents, told us they were encouraged to do so and that they received feedback following investigation of incidents.
- Incidents were investigated by senior nurses or the coordinator, according to the type of incident. Lessons learned were discussed at daily staff huddles and at more formal staff meetings and governance meetings. At a staff meeting in July 2016 it was reported that there had been an increase in incidents reported. The clinical lead nurse reported that this was perceived as a positive trend as it showed a culture in which staff felt empowered to raise concerns.
- In the 2015 staff survey, 94% of staff (organisation-wide) responded positively to the question, "If I was concerned about unsafe clinical practice, I would know how to report it". This compared favourably to the NHS response to the same question, which was 85%.
- A quality and harm free care report was produced each month, summarising incidents, identifying any themes and learning.

Duty of candour

- Staff were familiar with their responsibilities under the Duty of Candour regulation, and there was a prompt within the incident report form to consider Duty of Candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the organisation to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. No recent disclosures had been made in the urgent care centre under Duty of Candour; however, staff told us that they were open and transparent when mistakes were made. For example, if X-ray reports received following the patient's discharge revealed a fracture, which had been missed, the patient would be contacted and invited to attend the department again.

Safeguarding

- There were robust systems, processes and practices in place to protect adults and children from abuse.

Good

Are services safe?

- Staff were trained in these safe systems and demonstrated a good understanding of their responsibility to identify and act on suspected abuse. All clinical staff, with the exception of one new staff member had received safeguarding adults level 1 training and safeguarding children level 3 training. All non-clinical staff had received level 1 training for adults and children. There were named leads for safeguarding adults and children and staff were able to identify these individuals.
- There was guidance on the management of domestic violence and abuse, including a risk assessment checklist and information on how and where to seek support.
- Staff we spoke with were aware of their responsibility to report suspected cases of female genital mutilation (FGM). There was information accessible to staff on the UCC workspace (intranet).
- All children had a safeguarding assessment as part of their initial assessment at the UCC. Reception staff checked the child protection register and alerted clinical staff as appropriate. This included questions about who lived with the child and any involvement of social services. This was checked again at triage. Staff completed a children and young people's safeguarding checklist and communication form and all forms were scrutinised by the children's safeguarding lead. There were close links with the local children's hospital and staff could access advice from paediatric doctors via a 'hotline'.

Medicines

- Medicines were appropriately stored in locked cupboards, cabinets or fridges, although we noted the room in which they were stored was not locked. Medicines stored in fridges were stored at the correct temperature at the time of our visit and records showed that temperatures were regularly checked and were in the appropriate range. Stocks of medicines were audited weekly by a healthcare assistant and signed off by the senior nurse designated as the department's medicines lead.
- There was a lockable controlled drug cupboard within the urgent care centre where all the controlled drugs and records were stored. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- Stocks of medicines were available to be administered on site and stock levels were checked weekly.
- Prescription pads were stored in sealed and tagged bags (so that prescriptions could be traced) in locked cabinets. Each non-medical prescriber kept their own records of medicines prescribed. We checked these and they were accurate and complete.
- There was a range of patient group directions (PGDs) available for the nurse practitioners to use under certain circumstances. PGDs are agreements which allow some registered and appropriately trained nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We checked these on line and these were up-to-date.
- The department also aimed to have a non-medical prescriber working every day. In the absence of a non-medial prescriber, prescriptions were requested out of hours via the GP support unit or the local GP out of hours service.
- Patients' allergies were checked by staff and recorded before any medicines were prescribed or administered. We checked a sample of 10 patients' records and allergies were clearly documented in all cases.

Environment and equipment

- Facilities and equipment were well maintained and fit for purpose.
- The department was spacious and well laid out, with ample, well organised storage and ancillary areas. The department was in good decorative order, with surfaces intact and easy to keep clean.
- There was a dedicated ambulance entrance which allowed easy access to the resuscitation room.
- There were good lines of sight in the waiting room so that receptionists could observe patients.
- The department was well equipped and there were processes in place to ensure that equipment, including resuscitation equipment, was regularly checked. We checked the resuscitation trolley, which was fully equipped and all items were in date. Records were maintained to show that daily and monthly checks had been undertaken. The trolley was sealed following checks so that staff could be assured that it had not been tampered with.

- Consumable items, such as dressings were appropriately stored and regularly re-stocked. All consumable items we checked had packaging intact and were in date.
- There were appropriate arrangements for managing waste and clinical specimens. Clinical waste, including sharps was appropriately segregated, stored and disposed of.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare-associated infection. We saw staff comply with these safe systems. All clinical staff with the exception of one new member of staff, had completed annual mandatory training in infection prevention and control (IPC).
- The urgent care centre was visibly clean and tidy. Patients commented to us on the cleanliness of the department. We saw cleaning taking place during our visit by nursing staff and cleaning staff.
- We observed staff complying with recognised hand hygiene standards, including the requirement to be 'bare below the elbow'. There were numerous hand gel dispensers and hand wash sinks installed throughout the department and we saw staff and visitors using these to decontaminate their hands.
- There was a designated IPC link nurse in the department, who attended the organisation's IPC meetings and cascaded advice and support to their colleagues. They also conducted monthly hand hygiene audits. Results showed good compliance with standards: April 93%, May 97%, June 97%, July and August no data submitted, September 96%, October 96%. A cleaning audit, which took place in October 2016 scored 100%.
- There were notices at the entrance to the urgent care centre to advise patients suffering from diarrhoea and vomiting to go home and contact NHS 111 for advice. Receptionists alerted clinical staff if patients presented with infectious illnesses and steps were taken immediately to isolate them in a side room.

Mandatory training

- Staff received mandatory training in safety systems, processes and practices. Essential training included anaphylaxis, basic life support, infection prevention and control, safeguarding adults level 2, safeguarding children level 3 , clinical governance, conflict resolution, dementia awareness, equality and diversity, fire safety, fraud awareness, health and safety/risk management, information governance, Mental Capacity Act awareness, and moving and handling. Training records showed that all staff, except those who had recently joined the team, were up-to-date with all essential training.

Assessing and responding to patient risk

- Risks to patients were assessed and appropriately managed.
- The service had a standard operating procedure for triage. This was based on a recognised triage system (Manchester triage system) and described the process used to prioritise patients according to the urgency of their condition, and the responsibilities of different roles of staff in this process. Patients were categorised as emergency, urgent, complex or routine. Patients with life-threatening conditions were taken to the resuscitation room immediately.
- Reception staff received annual training on signs and symptoms of the sick adult or child, to enable them to prioritise any patients they judged to require immediate attention. They were able to refer to laminated cards, detailing categories of illness or injury and their priority status. For example, patients who were unresponsive were categorised as 'emergency', requiring immediate attention from a clinician. Patients categorised as 'urgent' were expected to be triaged by a clinician within 15 minutes of their arrival. All other patients, categorised as 'routine', would be seen in the order in which they arrived, and within a timescale of two hours.
- An audit had been carried out in April 2016 to assess whether receptionists had followed the triage process and prioritised patients appropriately. The audit showed that, out of 683 patients seen and categorised as routine, only five patients subsequently had their priority status upgraded when they were seen by a clinician. In four out of five of these cases the receptionist would not have known that the priority should have been higher because insufficient information was provided by the patient. In the fifth case, the patient was recorded as routine but the receptionist subsequently discussed the patient with a clinician and their priority status was upgraded. The

audit results showed that this was an effective and safe system of prioritisation. The annual training provided to receptionists and the good working relationship with clinicians was key in this.

- The urgent care centre monitored the time patients waited to be triaged. This was monitored closely by practitioners on a live system; however, historical data was not captured to show how the department performed against the standards set out in the standing operating procedure for triage. The senior nurse we spoke with acknowledged this was not ideal but they were confident that the system used to prioritise patients, significantly mitigated the risk that a patient might deteriorate in the waiting room and patients who waitedlonger had been assessed as safe to wait. Patients were seated in full sight of two reception staff, who would alert clinical staff to any concerns. Health care assistants told us they also spent time observing the waiting room and, on occasions, would conduct pre-triage observations or investigations on the instruction of, and under the supervision of, a registered nurse. During our unannounced visit, when the department was very busy, we observed the staff working together to ensure that those patients prioritised as urgent were triaged in the fastest possible time. The healthcare assistant took the initiative to undertake pre-triage observations and reported back to a registered nurse.
- All clinical staff were trained in basic life support and the use of an automatic defibrillator.
- Patients with mental health needs who attended the urgent care centre were assessed using a recognised mental health risk assessment, which had been adapted in consultation with the local mental health trust, to reflect local circumstances. Support and advice were available from the local psychiatric liaison service or the intensive (crisis) team run by the mental health service.

Staffing levels and caseload

- The urgent care centre employed an appropriate skill mix of staff to ensure safe care. The nursing team comprised of emergency nurse practitioners (ENPs), practitioners and health care assistants. ENPs are highly experienced practitioners who have a range of extended scope skills, such as non-medical prescribing, who can work autonomously. Some practitioners could order and read x-rays, make diagnosis and instigate first line treatment or make onward referrals.
- The daily staffing allocation was five practitioners (registered nurses or paramedics) and a healthcare assistant. It had recently been agreed to deploy six practitioners over the weekend, which was the department's busiest time. The department aimed to ensure there was always a non-medical prescriber, a practitioner with paediatric experience and a practitioner who has been deemed competent to read x-rays on duty.
- At the time of our inspection the department was staffed to its funded establishment. This had only recently been achieved. The department had been short staffed for some months and had relied on temporary staff to backfill shortfalls in the rota. The organisation had recently prohibited the use of agency staff for financial reasons, and with only a small bank of appropriately skilled nurses, the department was frequently under-staffed. This was in the context of a department which had seen a 26% increase in demand over the last 12 months. This meant, in order to maintain safe staff to patient ratios, the service was frequently restricted. Therefore, only those patients whose condition was considered to be serious (urgent) or life threatening would be seen. Other patients would be signposted to other sources of support or advised to return the following day.
- There was a morning 'huddle' held for 15 minutes at the start of each shift, where staffing and allocation was discussed, along with any other significant issues or anticipated events which may affect the smooth running of the shift. The nurse in charge was responsible for monitoring staffing levels throughout the shift, taking into account the number and complexity/acuity of patients who attended the department. In the event that staffing levels were not sufficient to deal with the number of patients attending the department, the nurse in charge would discuss the situation with the organisation's tactical manger and a decision to restrict the service may be made in accordance with the Managing Capacity Standing Operating Procedure.
- Staff were encouraged to report concerns about staffing levels and did so, although we could not be certain that the number of incidents reported reflected

the true level of concerns felt by staff. Some staff told us they were "exhausted" and "drained"; others expressed concern and regret that the quality of service was compromised, resulting in longer waits and disruption for patients. Both of these concerns were acknowledged by senior staff and were reflected in the department's risk register. A business case to increase staffing had been submitted to the clinical commissioning group and a decision was pending.

- The urgent care centre operational lead position had been vacant for approximately 10 months. The position had been advertised three times but recruitment to date had been unsuccessful. In the interim, leadership was provided by the clinical services manager, who spent one day a week in the department, supported by two part time clinical education leads and a coordinator. Surplus funding arising from the vacancy had been used to bolster the band 7 cohort and to increase administrative support.

Managing anticipated risks

- There were effective arrangements in place to manage patients safely when demand outstripped capacity. The Policy for the Management of Capacity and Acuity at Urgent Care Centre set out the process for restricting the service, to treat only patients whose condition was immediately life threatening or urgent. All other patients would be signposted to other sources of support or asked to return the following day.
- There were appropriate security arrangements to keep staff and others safe and protected from violence. The department had CCTV, intercom systems, and panic alarm systems to protect patients and staff. Security staff were based within the hospital and could be summoned by using the panic alarm system. Staff told us this was rarely required and they were confident that calls for assistance would be answered promptly. All staff had received conflict resolution training, with the exception of one new staff member.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as good because:

- People had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice,during assessment, diagnostics and referral to other services. Staff had access to a range of national guidance, local protocols and referral pathways.
- The service monitored the effectiveness of, and compliance with, processes and referral pathways. Audits showed that patients were appropriately prioritised on arrival in the department and referrals to out of hours primary care were appropriate.
- Staff, including those in different teams, worked together to provide seamless and coordinated care. Staff had access to remote advice and support from healthcare partners.
- There were clear and effective arrangements for referrals to other services. A range of referral pathways for adults and children had been developed with healthcare partners. Ongoing dialogue and feedback from these partners ensured that referrals continued to be appropriate.
- Staff were suitably qualified and experienced to undertake their roles and were supported and encouraged to update and extend their skills and to develop areas of interest.
- The staff had extensive experience from a variety of backgrounds, including emergency care, primary care and pre-hospital care.
- Patients' pain was assessed and managed appropriately.

However:

- Consent to care and treatment was not consistently recorded in patients' records.

Detailed findings

Evidence based care and treatment

- People had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice, during assessment, diagnostics and referral to other services. Staff had access to a range of national guidance, local protocols and referral pathways, which had been developed with healthcare partners in emergency medicine and other specialties.
- There was a range of written information given to patients about their condition and treatment. This included information about what symptoms to expect, self-management and when to seek help.
- The urgent care centre was participating in a number of research projects. This included a joint study by the British Red Cross, the University of Bristol and the University of the West of England, aimed at better understanding the drivers for attendance at urgent, unscheduled and emergence care services. There were also two university based studies ongoing, each looking at the role of an advanced nurse practitioner.

Pain relief

- Patients' pain was assessed and managed effectively.
- Patients we spoke with confirmed they had been asked about their pain and offered pain relief. We observed staff asking patients about their pain at triage and, where appropriate, they were offered and/or administered appropriate pain relief. Staff used a numeric pain rating tool for adults and a pictorial tool with happy and sad faces for children. Some patients were not triaged promptly; there was therefore a risk that any required pain relief may be delayed. However, receptionists told us they would always alert clinical staff if a patient indicated severe pain when they booked in. This was in accordance with the triage category guide which they worked to. We saw this occur during our inspection.
- During our unannounced inspection, when the department was very busy, the nurse in charge made an announcement to patients in the waiting room who were waiting to be seen, explaining and apologising for the wait. They advised any patients who were in pain to let staff know so that they could be prioritised for pain relief.
- The urgent care centre had recognised that they were unable to provide effective pain relief to some patients

who presented with moderate or severe pain. They had developed a proposal to introduce nasal diamorphine for children, intravenous paracetamol for adults with isolated limb trauma or renal colic and intravenous morphine for adults presenting with suspected acute myocardial infarction. The proposal was to be considered by the organisation's Clinical Cabinet. The Clinical Cabinet was a sub committee of the organisation's Quality Assurance and Governance Committee, and was responsible for reviewing and ratifying clinical policies and guidelines.

Nutrition and hydration

- People had access to food and drink. Jugs of drinking water were available at reception. There was a vending machine in the waiting area dispensing cold drinks and snacks and a cafeteria was located in the main hospital entrance. Staff told us that they made hot drinks for patients in some circumstances, for example if they had experienced a long wait. There was a range of snacks available for people who required food for medical reasons, for example diabetic patients.

Patient outcomes

- The service monitored the effectiveness of, and compliance with, processes and referral pathways. There was an audit programme for 2016/17. The department had not been able to complete all planned audits due to shortage of staff, including the vacant operational lead position. However, audits completed to date included a patient records audit and a receptionist priority audit (to assess whether patients were appropriately prioritised when they booked in).
- In April 2016 an audit was undertaken to evaluate the referral pathway to the local GP out of hours service. This included assessing the standard of referral documentation, the appropriateness of interventions initiated at the urgent care centre and whether referrals were appropriate. The audit found that 82% of referrals to the out of hours service were appropriate and 100% of the referral documentation was appropriate. The management of patients in the urgent care centre was also found to be appropriate in 82% of cases. The main omissions related to medicines management. Although these were not considered to be patient safety issues, an action arising from the audit was to encourage urgent care centre practitioners to seek telephone advice or remote prescribing for more complex medicines management issues.
- There was an audit of fracture management ongoing at the time of our inspection. There was a system in place to reconcile all radiology reports with patients' recorded in order to identify any missed fractures. A practitioner was allocated each day to check incoming radiology results and inform relevant practitioners of any results which did not reconcile with the initial interpretation of x-rays.

Competent staff

- Staff were suitably qualified and experienced to undertake their roles and were supported and encouraged to update and extend their skills and to develop areas of interest. The staff had extensive experience from a variety of backgrounds, including emergency care, primary care and pre-hospital care.
- There was a comprehensive local orientation programme for new staff, which set out tasks to be completed at two weeks, one, three and six months of employment. The programme included time spent with local healthcare partners such as the fracture clinic, the local eye hospital and the GP support unit. New staff were reviewed at three and six months.
- Education and clinical supervision were managed by two part-time clinical education leads. The department had developed a range of essential and desirable nurse competencies for the department. This had involved consultation with other stakeholders and healthcare partners, such as emergency departments and the fracture clinic. A baseline assessment was being undertaken through self-assessment and supervision, and this informed the education programme.
- Ongoing learning needs were identified through appraisal and clinical supervision. As at September 2016, 94% of nursing staff had received an appraisal in the last 12 months. All staff were allocated a mentor and were required to undergo a minimum of two hours of observed practice per year, one hour with their mentor and one hour with a peer. To facilitate this, from September 2016, clinical supervision slots were incorporated into the rota.
- There were three registered children's nurses and the adult-trained registered nurses had experience and/or extended skills/ qualifications to care for children. The

department had secured the support of the lead consultant in the emergency department at the local children's hospital through an honorary contract and there were plans to develop a joint education programme with the emergency department, including the development of rotational posts.

- There were weekly training sessions for staff. These covered a range of topics and were led by both internal staff and outside speakers. Teaching sessions normally took place on Wednesdays (known as "Wise Wednesdays"). Attendance was facilitated where possible and sessions were adapted according to the availability of staff. Training material was emailed to all staff and uploaded to the intranet so that all staff could access the learning. Topics covered included areas which had been highlighted by audits, patient feedback or through supervision and appraisal. There had been a number of teaching sessions, for example on nurse documentation, following an audit which had identified some areas for improvement. On the first day of our inspection there had been a teaching session led by the lead children's nurse on bronchiolitis, which is particularly prevalent in children during the winter months.
- There was a programme of evening seminars, which were open to all urgent care centre staff and external health care partners. In October 2016 a dermatology nurse specialist ran a session on rashes, eczema and psoriasis. The next session, planned for December 2016 focussed on dental care.
- Staff received monthly clinical education updates and periodic 'learning bites' by email.
- Staff were encouraged and given opportunities to develop. Staff were supported to undertake additional training, such as training to qualify as an emergency nurse practitioner/ emergency care practitioner and a non-medical prescribing course. A health care assistant was being supported to undertake an assistant nurse practitioner course and patient liaison officer was supported to undertake a National Vocational Qualification in business and administration.

Multi-disciplinary working and coordinated care pathways

- Staff, including those in different teams, worked together to provide seamless and coordinated care.
- There was an x-ray department on the hospital site, run by the local acute trust, providing plain film imaging. The service level agreement between the two parties specified that patients referred by the urgent care centre would have their x-ray performed within 30 minutes and reported in 92 hours. Staff reported there was good working relationship with the x-ray department and patients told us during our inspection that they had their x-rays performed without undue delay. Staff were able to discuss x-ray images with radiographers, or they could access support from the radiology department at the local acute trust. An electronic picture archiving and communication system allowed remote interpretation of images.
- There were clear and effective arrangements for referrals to other services. A range of referral pathways for adults and children had been developed with healthcare partners. These included pathways for the emergency transfer of adults and children to the most appropriate emergency department, urgent or routine referrals to GPs, both in and out of hours, direct referral to inpatient specialists at the local acute hospital and psychiatric support pathways, developed with the local mental health trust. Staff could also refer to Bristol Community Health's single point of access and onward referral to a range of support services designed to avoid hospital admission.
- Staff worked closely with patients' GPs; this may be to discuss a patient's medical history or medication or to facilitate an appointment.

Access to information

- Staff had access to information needed to deliver effective care and treatment. Staff could access a dedicated intranet workspace and an A to Z directory where staff they could access clinical pathways, guidance, policies and standing operating procedures.
- Staff had access to electronic systems to request and view x-rays and pathology.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- We observed nurses asking patients' permission before they undertook examinations or provided care or treatment. Patients who had undergone tests told us the reasons for these tests had been explained to them.

Good

Are services effective?

- Staff had completed training in the Mental Capacity Act 2005 and demonstrated knowledge and understanding of their responsibilities in relation to those patients who did not have capacity to consent.
- Consent was not well documented in patients' notes. In a sample of 10 patients' records only one had consent documented.

Outstanding ☆

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated this service as outstanding because:

- There was a highly visible person-centred culture. Staff consistently provided compassionate care to patients and those close to them.
- Feedback from patients and those close to them was consistently positive. The department received overwhelmingly positive feedback from patients and this was consistent with the feedback we received during our inspection. Patients we spoke with were fulsome in their praise for staff. We heard of numerous examples where staff had "gone the extra mile" to support people.
- Staff treated patients with dignity, respect and kindness during all interactions. Patients told us that staff took time listen to them and felt supported by them.
- Patients and those close to them were involved as partners in their care. Patients told us that their conditions and treatment options were explained to them in a way they could understand.
- Staff showed compassion when people were distressed, anxious or in pain.

Detailed findings

Compassionate care

- There was a highly visible person-centred culture. Staff consistently provided compassionate care to patients and those close to them.
- Patients and their relatives were treated with kindness, dignity, respect and compassion. In the period April to September 2016, 91% of patients who responded to the friends and family test said they were extremely likely or likely to recommend the service to friends and family.
- These positive scores were mirrored by the consistently positive feedback we received during our visit.Comments included:
  - "This service is brilliant, the best thing to happen to Bristol; staff are brilliant; they treat you as a human being and they are so kind."
  - "I'm very happy with the service and have experienced it many times. All the staff have been great, friendly, professional and sincerely caring too."
  - Fantastic reception staff - very helpful nurses - thank you"
  - "All outstanding – everybody friendly and helpful."

Other patients described staff "friendly", "fantastic and really lovely" and very, very attentive".

- Patients frequently sent cards and letters to the staff to show their gratitude for the service they received, and a sample of these was displayed in the department.We saw a number of examples where staff's actions had exceeded patients' expectations. One patient had written: "thank you, I know it's your job but you will never know just how much your help yesterday meant to me after the week I had. I was in a very low mood due to pain. Yesterday you restored my faith." A relative had written "Firstly, thank you for being brilliant at your jobs. Secondly, for going way above and beyond when the car wouldn't start. Having you stay with us while we waited for the ambulance, even though you had finished work, was so kind and comforting." Another patient, who had injured themselves when they were about to catch a plane to go on holiday, wrote "Thank you for rushing me through. You went above and beyond any expectations to help us."
- The department coordinator shared with us numerous examples of occasions where reception staff had "gone the extra mile" to support patients. These included:
  - Escorting an elderly patient to the bus stop and ensuring they got on the bus safely
  - Staying after working hours, and when the service was closed, to help a patient who had collapsed outside the hospital. The staff member alerted a nurse, went outside with a wheelchair, called an ambulance and waited with the patient until the ambulance arrived.
  - A patient who was brought in a taxi to the urgent care centre in error had no money for their onward journey. The receptionist lent them money from their own purse.
  - An elderly patient accidently left their walking aid on the bus. The receptionist made enquiries on their behalf and managed to get the walking aid replaced.

Outstanding ☆

Are services caring?

- Staff were polite, friendly and respectful. We heard staff introduce themselves to patients by name and by role and chat to them in a friendly manner.
- 100% of patients who provided friends and family feedback between April and September 2016 said they had been treated with respect.
- We saw staff take time to interact with patients and those close to them in a sensitive and considerate manner. Consultations were unhurried, allowing patients time to discuss their concerns. We observed an elderly patient during their triage consultation. The patient had fallen and had a complex medical history. The nurse asked them questions about their home situation to ascertain whether they had sufficient support. They offered advice about steps they could take if they had another fall and could not pick themselves up off the floor. This initial consultation was supposed to last only a few minutes but the nurse showed sensitivity and compassion with regard to this patient's social circumstances and spent more time with them to ensure they captured a full picture of their complex needs.
- During our unannounced visit we observed that a nurse spent some time, making numerous phone calls, to arrange for a patient, who had a terminal illness, to be seen for further investigation at the local acute hospital, without having to go through the emergency department, where they would likely experience a long wait.They showed great compassion for the patient's circumstances.
- Staff took steps to make sure patient's privacy was always respected, including during physical and intimate care. At the reception desk it was difficult for patients to describe their problem to the receptionists without being overheard by others. However, the receptionists checked that people were happy to describe their condition verbally and offered people the opportunity to write something down or they simply recorded their condition as personal. There was quiet music played to help to prevent conversations being heard by others in the waiting room.
- Patients' care and treatment was provided in private treatment rooms, with glass panels which could be obscured when the rooms were in use. We observed staff knocking on treatment room doors before entering. Patients were offered chaperones where intimate examinations took place. Curtains were used to protect patients' privacy when they undressed.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. Patients and relatives told us that each stage of their care and treatment was explained to them in a way they could understand.
- A health care assistant described to us how they had recently supported the parents of a very unwell child, offering comfort and cups of tea.
- We heard a receptionist offering reassurance to the anxious parents of a sick baby, letting them know that their child would be seen as a priority.

Emotional support

- People's emotional and social needs were highly valued by staff. They showed empathy and understanding when patients were distressed. During our inspection we learnt that a nurse, who was due to attend a training course, did not attend because they felt compelled to provide emotional support to a patient who became distressed about the impact that their injury would have on their ability to cope independently at home.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated this service as good because:

- The urgent care centre provided a convenient and accessible service for patients who could not access primary care services and/or who may have otherwise presented at an emergency department.
- Staff took steps to support patients in vulnerable circumstances and those with complex needs.
- People's complaints and concerns were listened to and responded to. Learning from complaints was used to improve the quality of care.

However:

- Patients were not always able to access care and treatment in a timely way. Increasing demand and periods of under-staffing resulted in the frequent restriction of the service.

Detailed findings

Planning and delivering services which meet people's needs

- The urgent care centre provided a convenient and accessible service for patients who may have otherwise presented at an emergency department. Services were provided to patients who could not access treatment through their GP, were not local to the area or were not registered with a GP. Patients we spoke with valued the local service.
- Activity was monitored by the service and information about the reasons why people used the service was captured to inform future planning of the service. Receptionists asked patients where they would have sought help if the urgent care centre was not open. The service had seen a 26% increase in demand over the last 12 months and discussions were ongoing with the commissioners of the service to seek additional funding in order to increase staffing. In the meantime, the service was frequently restricted and at these times, only able to see those patients whose conditions were serious or life threatening.
- Bristol Community Health was participating in a campaign to educate people to use unplanned services appropriately. At the entrance to the urgent care centre a sign was displayed describing the options available to patients, including contacting NHS 111, contacting their GP or visiting their local pharmacist.
- Facilities and premises were mostly appropriate for the services which were planned and delivered.
- The department was well signposted and easily accessible by car or by public transport. There was car parking on the hospital site, including a number of disabled bays. There was a drop off point to enable patients, who could not walk from the car park, to be dropped just outside the entrance to the department. It was not clear whether visitors were able to park here for a short period while they escorted patients into the department, although staff told us this was how the area was commonly used. A number of patients and staff told us parking was limited and it was felt to be too expensive.
- The department was large, spacious and well lit. Facilities were laid out on one level and were easily accessible for people with limited mobility or those who used a wheelchair. The department was well equipped with a large waiting room, equipped with adequate seating, including high-backed chairs with arms for people with limited mobility. There was a television, vending machine, magazines, and play equipment provided for children. There were male and female toilets, nappy changing and breast feeding facilities. Some patients complained that they could not access Wi-Fi in the centre. We noted there was no hearing loop at the reception desk. This is s a special type of sound system for use by people with hearing aids. When we raised this with reception staff they found the equipment in the store room and immediately installed it.

Equality and diversity

- There were no barriers to any patients attending the urgent care centre in relation to their age, gender, race, sexuality, pregnancy status or any of the other protected characteristics. The premises were easily accessible to disabled people. Telephone interpretation services were available and printed material could be obtained in different languages and formats.

Good

Are services responsive to people's needs?

- All staff had received equality and diversity training. Data was collected and analysed to show the profile of patients who attended the urgent care centre, in terms of protected characteristics.
- The service was taking steps to comply with the Accessible Information Standard. This is a legal requirement for all NHS organisations to meet the communication needs of people with a disability, impairment or sensory loss. Reception staff were undergoing training to support their understanding and responsibilities under this standard.

Meeting the needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take account of people in vulnerable circumstances or those with complex needs, for example, those living with dementia or those with a learning disability.
- The triage system prioritised people with complex needs, such as those with anxiety or other mental health issues, patients living with dementia or patients with a learning disability. Staff we spoke with recognised certain groups of patients required additional support. They told us they would sometimes arrange for anxious or disorientated patients to wait in a side room. During our unannounced visit we saw staff prioritising patients under two and over eighty years of age. We saw a patient, who had a terminal illness, and whose treatment may have suppressed their immune system, was taken to a side room to wait so they were not exposed to infections.
- Staff had received mandatory training in dementia awareness.

Access to the right care at the right time

- Patients were not always able to access care and treatment in a timely way.
- Increasing demand and periods of under-staffing resulted in the frequent restriction of the service. This meant that the service was only able to see patients whose condition was considered to be immediately life threatening or urgent. The Policy for the Management of Capacity and Acuity at Urgent Care Centre set out the circumstances in which restriction would occur, based on the numbers and acuity of patients attending the department and the number and skill mix of staff.
- Signs placed at the entrance to the department explained to patients, in peroods of high demand and/ or shortage of staff, only patients who considered their condition to be serious or life threatening would be seen. All other patients were advised to consider other options, such as visiting their pharmacist, contacting NHS 111 or returning the following day. In the period 30 May 2016 to 13 November 2016 the service was restricted, on average, five times a week. This was usually for periods of between one and three hours.
- Staff kept patients informed about waiting times. Receptionists periodically updated an electronic notice to advise patients approximately how long they might wait to be seen. Patients we spoke with during our inspection told us they had been informed about waiting times and they were happy with the explanation they had been given.
- On occasions, when there were long delays, for example, if staff were dealing with a life threatening emergency, the nurse in charge would make an announcement to waiting patients to explain the delay. We saw this occur during our unannounced visit. This resulted in some patients choosing not to wait to be seen.
- Staff worked as a team to improve patient flow. For example, receptionists pre-empted the need for patients to provide a urine specimen and directed them to do this while they were waiting to be seen. Healthcare assistants supported the triage process by undertaking observations and tests under the supervision of a registered nurse.
- In the period October 2015 to September 2016 the urgent care centre exceeded the national target which requires that 95% of patients are seen, transferred or discharged within four hours, achieving 98%. Waiting times to be seen during this period were as follows:
  - 0-1 hour: 36%
  - 1-2 hours:31%
  - 3-4 hours:19%
  - More than four hours: 2%
  - Left before being seen (usually indicative of dissatisfaction with waiting time): 3%.

Learning from complaints and concerns

- People's complaints and concerns were listened to and responded to. Learning from complaints was used to improve the quality of care.

Good

Are services responsive to people's needs?

- There were complaints leaflets available at the reception desk, which explained to people how they could raise a concern or make a formal complaint. Reception staff told usmost complaints were made verbally to them and they always offered the complainant the opportunity to speak with a senior member of staff.
- All complaints were investigated by a senior nurse or the urgent care centre coordinator. Records were maintained and discussed locally at staff and governance meetings, and monitored both locally and centrally.
- There had been five complaints received in the urgent care centre since January 2016. We reviewed these complaints and saw no discernible trends. Complaints had been fully investigated and complainants had received a full and timely response, explanation and apology, where appropriate. One complainant had indicated their ongoing dissatisfaction and was seeking an independent review of their complaint by the Parliamentary and Health Service Ombudsman.
- Real-time surveys could be completed by patients and scores less than 50% would result in an instant email to the team manager so that they could investigate and take any necessary action, including contacting the individual to discuss their concerns.
- The organisation reported in its Quality Accounts 2015-16 that a number of improvements had been made in the urgent care centre in response to complaints. The department had introduced dedicated time for a nurse to audit every x-ray which was taken, ensuring that if a nurse initially missed something, this was picked up quickly. The department also produced an abdominal protocol for patients with increasing and / or changing abdominal pain.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated this service as good because:

- The local leadership team was well respected, visible and accessible. Staff were inspired by and supported by a strong and cohesive leadership team.
- Staff enjoyed working in the urgent care centre. The department had experienced a difficult year, with high demand, high staff turnover and staffing shortage, including holding a management vacancy. In spite of this, morale was high, staff expressed pride in their service and they were optimistic for the future.
- Team work was cited by many staff as the best thing about working in the urgent care centre. We saw excellent cooperative working within and without the urgent care centre.
- There were effective governance arrangements. Information was regularly monitored to provide a holistic understanding of performance, including safety, quality and patient experience.
- Patients and the public were engaged and involved. Their views were captured and acted upon to shape and improve the service.
- There was a strong focus on learning and improvement. Audit was used to drive improvement, mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient safety and quality.

However:

- The results of the 2016 staff survey had been mixed, with some concerning messages emerging relating to pressure of work.

Detailed findings

Service vision and strategy

- The organisation had developed a vision: “for all our communities to lead healthier, better lives” and a mission: “to provide person-centred patient care. Staff in the urgent care centre, whilst not able to articulate these, demonstrated passion and commitment to achieve these goals.
- Staff talked about “touching lives” and the values and behaviours which underpinned their approach to care.
- The urgent care centre had not developed a strategy or business plan for the service. The organisation told us that this had not been a priority when the department was experiencing staffing pressures, and was without an operational lead. A business case for additional staffing was being considered by commisisoners at the time of our inspection and we were told that a full service development plan would be developed based on this over the forthcoming three months.

Governance, risk management and quality measurement

- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, including safety, quality and patient experience.
- There were alternating monthly clinical governance meetings and general staff meetings held in the urgent care centre. Standing agenda items included incidents, complaints and other patient feedback, medicines management, infection control, safeguarding, staffing, supervision, education and training. We noted that meetings were not consistently well attended; this was most likely due to staffing constraints in the department. However, minutes were circulated by email to all staff and posted on the department’s intranet workspace. In October 2016 it was recorded at the general staff meetings that weekly quality messages had been introduced. Topics had included record keeping, verbal communication, safeguarding, medicines management, infection control and clinical supervision.
- There were effective arrangements for identifying, recording and managing risks, issues and mitigating actions. There was risk register for the urgent care centre. At the time of our inspection two risks were identified. These related to the failure to appoint to the operational lead role for the department and capacity in the context of increasing demand. Both of these risks were consistent with the concerns described to us by staff and managers. Risks were reviewed monthly to assess whether mitigating actions were effective.

Good

Are services well-led?

- There was a systematic approach to working with other organisations to improve patient experience and outcomes. The urgent care centre had developed strong links with healthcare partners in secondary, primary and pre-hospital care. There was a range of referral pathways and access to support and advice from these partners, as well as ongoing dialogue and feedback to ensure continuing cooperative working and appropriate onward referral. The department had worked with the local mental health trust to develop a mental health assessment tool and onward referral pathways to ensure that patients with mental health needs received the most appropriate support.

Leadership of this service

- The local leadership team comprised the clinical service manager, who worked in the department one day a week, supported by two clinical education leads and the coordinator, all of whom had taken on additional responsibilities due to the long standing vacancy of the department's operational lead. This position had been vacant for approximately 10 months and recruitment had been unsuccessful. Despite this, all of the staff we spoke with felt that the department was well led. They felt inspired and motivated by the interim management team. Staff described them as a cohesive and supportive team, who were visible and approachable.
- Staff told us they felt supported by their organisation. Members of the senior management team, executive and non-executive directors, whilst not regular visitors to the department, had attended staff meetings. In July 2016 a non-executive director had attended a meeting and listened to staff concerns with regard to staffing and capacity. However, in the 2016 staff survey, 28% of staff disagreed with the statement "our board is sufficiently visible" and only 14% of staff indicated they had confidence in directors and senior managers.
- Managers acknowledged the pressures placed upon staff over the last 12 months due to increasing demand and staff shortage. They demonstrated genuine concern for staff wellbeing and staff appreciated the steps they were taking to address concerns about capacity.

Culture within this service

- There were high levels of staff satisfaction. All of the staff we spoke with during our inspection told us they enjoyed working in the urgent care centre. Comments included "I love my job" and "this is a lovely place to work". Team work was cited by all staff as one of the best things about working in this department. In the 2016 staff survey 93% of staff agreed with the statement "People within my team actively support each other." Staff told us they were "one big happy family", with a common purpose centred upon delivering the best possible service to patients. Staff told us there were no divisions between managers, nurses or support staff and their relationship was based on mutual respect and admiration for one another. The positive attitude demonstrated by all staff was all the more remarkable, given the difficult 12 months they had experienced, with staff shortage and a vacant manager's position.
- In the 2016 staff survey, feedback had been mixed. This was possibly indicative of the department's recent history. Eighty-six percent of respondents indicated they were happy at work, and no respondents indicated they may leave the organisation in the next 12 months. There was negative feedback however, in relation to staffing levels and pay. Twenty-one percent of respondents indicated they did not have enough time to do their job properly and there was a similar response in relation to working excessive hours in order to meet the requirements of their job. Twenty-eight percent of respondents said there were not enough staff for them to do their job properly and 64% of staff said they had come to work despite not feeling well enough as a result of work pressures. Fourteen percent of staff indicated that they had felt unwell due to work related stress in the last 12 months. Fifty percent of staff indicated dissatisfaction with their level of pay.
- There was a great sense of pride and passion demonstrated by all levels of staff. One staff member's comments summed up the sentiments expressed by many: "I am proud of the team and the patient care we provide."
- There was a culture of openness and honesty. Staff told us they could raise concerns and they would be listened to.
- The urgent care centre had experienced a high level of staff turnover (36%) in the last 12 months and periods of significant staff shortage. Staff told us this had been a difficult time for them but they were proud of the fact they had pulled together to overcome these difficulties. The department was now fully staffed with the exception of the operational lead position. The

department was proud of the fact that it had increased the band 7 team from one to nine staff in a period of seven months, and staff were optimistic about the future.

- Staff felt respected, valued and supported; their contribution was acknowledged and their achievements were celebrated. The administrative assistant and the receptionist team had been nominated in 2015 by their manager for an award to recognise their contribution to the department. The receptionist team had previously won awards in 2010, 20111 and 2013, which they were presented with at an annual awards ceremony, which all staff could attend. One of the clinical education leads had recently won an award for 'outstanding moments of care'. The coordinator proudly showed us a hand written card from the chief executive, thanking them for their service.
- There was a focus on staff wellbeing within the organisation. Recognising the impact of increasing demand and staffing issues, the organisation had launched the Happiness and Wellbeing Programme, aimed at improving the mental and physical wellbeing of staff and finding ways for them to be happier at work. The programme, which launched in early 2016, had seen 25% of staff take advantage of one or more of the schemes and benefits on offer, including a range of salary sacrifice benefits, the ability to buy and sell leave.

Public engagement

- Patients and the public were engaged and involved. Their views were captured and acted upon to shape and improve the service.
- The department used innovative approaches to gather patient feedback. The department had designed posters, which were displayed in the waiting rooms, and which encouraged patients to provide feedback by speaking with staff, completing a "How are we doing?" card or using their smart phone to scan a barcode, which linked them to an online feedback system. "You said, we did" messages demonstrated the department's commitment to listen to and act on patient feedback.
- The urgent care department had developed a patient experience action plan in response to friends and family feedback gathered from April to September 2016. Although 91% of 1309 respondents indicated they were extremely like or likely to recommend the urgent care centre to their friends and family, there were a number of areas for improvement identified.
- Actions included reviewing staffing levels during busy times, producing clearer information at reception if the service was restricted, verbal communication whilst patients were waiting if waits were further delayed by emergencies, ensuring patients were given clear written information to help them and ensuring that they were satisfied with the consultation and treatment they received. Many of the actions had been completed or were ongoing. There were a number of posters displayed in the waiting which described actions which had been taken in response to patient feedback. For example, patients had complained about hard chairs in the waiting room, and cushions had now been made available and could be requested from reception. Another comment had been received that there were insufficient toys for children to play with and insufficient magazines for people to read while waiting. In response to this, staff had brought in magazines and toys from home and members of the public were being encouraged to donate unwanted toys. During our inspection a grateful patient came to the urgent care centre to donate a large sum of cash so that play equipment could be purchased for the waiting room.
- The department had also designed a number of posters displaying frequently asked questions and answers. For example, "why can't you tell me when I am going to be seen?"
- The department was taking steps to improve the response rate in the friends and family test. A receptionist had been designated as the lead for this and they were responsible for collating feedback. In order to encourage staff to hand out comments cards, the receptionist had encouraged them to mark each card they gave out with their initials. The staff member who received the most returned cards each month was awarded a prize. The department was also attempting to recruit a volunteer to help to promote the scheme.

Staff engagement

- Staff told us they felt well informed and felt that their views were listened to. They told us team meetings were inclusive and that their views and contributions were encouraged and welcomed.

Innovation, improvement and sustainability

- There was strong sense of drive to improve the service. In the 2016 staff survey 93% of staff agreed with the statement "My team regularly looks at ways to improve

Good

Are services well-led?

services." Staff at all levels were encouraged to play their part in improving patient safety and quality. There were designated leads and champions who were able to develop their areas of interest while providing support and guidance to the rest of the team. For example, there were leads for infection control, medicines management, safeguarding, wound care, community liaison and sexual health.

- There was a strong focus on, and commitment to, education, learning and improvement. The education programme was informed by feedback from other healthcare partners, from staff and from incidents and patient feedback.
- The department had recently secured the support of the lead emergency consultant at the local children's hospital through an honorary contract. This relationship would support clinical practice, clinical pathways and a joint education programme. There were plans to develop rotational posts between the two units in the future.
- The urgent care centre, previously nurse led, had developed a multidisciplinary team with a wide skills and experience base. The team included both adult-trained and children's nurses from primary care, emergency care and pre-hospital care. A physiotherapist had played a vital role in setting up fracture pathways and there were plans to further develop the service to provide a soft tissue clinic. The department was looking at the possibility of employing radiography practitioners and pharmacy technicians.