Great Western Hospitals NHS Foundation Trust

RN3

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)
RN325	Great Western Hospital		

This report describes our judgement of the quality of care provided within this core service by Great Western Hospitals NHS Foundation Trust. 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 Great Western Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Great Western Hospitals NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated the urgent care centre to be requires improvement overall. This was because:

- We were concerned that following a serious incident the service did not explore all possible areas of improvement.
- Not all staff had received the appropriate level of safeguarding training which put patients at risk.
- Some medicines were not stored securely and some were not labelled correctly which meant it could not be identified when they were opened.
- The quality of records required improvement and the records audit process was not robust
- Compliance with mandatory training was variable so we could not be assured that staff were familiar with safe systems and processes.
- The business continuity plan was not robust to account for different situations such as adverse weather.
- There were incidents of inappropriate referral from the emergency department of patients who were too ill to be in the urgent care centre. Patients were sometime inappropriately streamed to the urgent care centre by the emergency department, NHS 111 and the ambulance service.
- Due to the computer systems in the emergency department and the urgent care centre being different, patients may be waiting up to eight hours without being outside of target times.
- Some patients did not have the waiting times explained to them which left them uncertain as to why they were waiting.
- Staff were uncertain about the future of the urgent care centre and required more reassurance from managers during the transition period.

However:

- Managers had recognised where services could be improved and various work streams were in place to mitigate and improve them.
- Staff understood their responsibilities to raise concerns and report incidents. Learning from incidents was shared with them.
- Staff held the appropriate qualifications and training to perform their role. Staff were given opportunities to develop and improve their skills and to progress within the service.
- Staff worked well with other services, such as NHS 111, the ambulance service, GP's and, particularly ambulatory care, to ensure that treatment was effective.
- Feedback from patients was positive about the way staff treated them. Patients were treated with dignity, respect and kindness during all interactions.
- Staff encouraged patients to be partners in their care and supported them to make decisions. Staff responded compassionately when people needed help.
- Confidentiality was respected at all times.
- The department consistently met or exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the urgent care centre.
- There was suitable support provided to patients with complex needs such as patients living with dementia or a learning disability. Staff understood the reasonable adjustments needed to ensure vulnerable people were cared for appropriately.
- The urgent care centre was accessible by patients with a disability and chaperone and translation services were available.
- Governance and performance management systems were being proactively assessed and established. The centre had set up a dashboard and governance processes in line with processes in the wider trust and were using them to monitor performance
- The urgent care centre used risk registers to identify where the biggest risks were and they were taking steps to mitigate known risks.
- Leadership the urgent care centre were proactive and well respected. The leadership within the unscheduled care division had the skills needed to integrate the urgent care centre with the division.
- Despite the amount of change going on within the urgent care centre, staff morale was positive; staff felt respected, valued, and supported by their leadership team.

Summary of findings

Background to the service

The urgent care centre 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.

CQC inspected the urgent care centre at a time of significant change. In October 2016 the service was transferred from the previous provider to Great Western Hospitals NHS Trust. Prior to October 2016 the service was run by an independent organisation.

Prior to the inspection the trust had undertaken a due diligence process to assess the service. A due diligence process is a comprehensive appraisal of a business to established the quality of the service prior to the acquisition by Great Western Hospitals NHS Trust.

On this site two services are provided. A nurse led urgent care centre provides care and treatment to patients during the day, seven days a week. Out of hours services are provided by GP services which was not inspected as part of this inspection.

Between April 2016 and February 2017 the unit saw 26,265 patients, with 8761 being under the age of 19 years. The service employed a team of 20 nurses, nurse practitioners and paramedics.

During this inspection we spoke with nine staff, four patients and relatives and received 10 comment cards from members of the public.

Our inspection team

Our inspection team was led by:

Chair: Julie Blumgart, invited independent chair.

Head of Hospital Inspections: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: An accident and emergency nurse, two junior doctors with experience of working in the accident and emergency department, a matron with experience of working in medicine, a medical doctor, a theatre nurse, a surgery matron, a consultant surgeon, a critical care consultant, a critical care nurse, a paediatric consultant, a paediatric nurse, two outpatients nurses, a board level director, a pharmacist, a clinical fellow and an expert by experience.

How we carried out this inspection

We carried out the announced part of our inspection between 24 and 27 March 2017 and an unannounced inspection at Great Western Hospitals Hospital on 27 and 28 March 2017 and 3 April 2017.

During the inspection we visited a range of wards and departments within the hospital and spoke with clinical and non-clinical staff, patients, and relatives. We held focus groups to meet with groups of staff and managers.

Prior to the inspection we obtained feedback and overviews of the trust performance from local Clinical Commissioning Groups and NHS Improvement.

We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

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?

Summary of findings

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

What people who use the provider say

- "They put me at complete ease even when I was worked up"
- "I could not have received better care".
- "I have been here several times and the nurses are always brilliant, they are really friendly and helpful".

Good practice

The detail within the monthly newsletter for staff from the urgent care centre to read. This contained information on departmental news, department performance and updates on policies and procedures.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- Improve the rates of mandatory training within the urgent care centre to bring compliance levels in line with the trust's target.
- Improve the storage of medicines within the urgent care centre and ensure that medicines are checked and managed by staff.
- Improve the quality of records audits in the urgent care centre to ensure that maximum learning was taken from them.

Action the service SHOULD take to improve

Great Western Hospitals NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement. This was because:

- The process for investigating serious incidents was not robust. Action plans following serious incident did not explore all possible areas of improvement.
- Not all staff had completed the appropriate level of safeguarding training. No staff were trained to level three child protection.
- Some medicines were not stored securely and could be accessed by many staff members, some of which were from a different organisation.
- Some medicines were not labelled correctly with open dates which meant it could not be established how long they had been opened.
- According to records audits patients' records were not always completed to a high standard and the records audits process was not robust.
- Compliance with mandatory training was variable so we could not be assured that all staff were familiar with safe systems and processes.
- The business continuity plan was not robust to account for different situations such as adverse weather.

However:

- Managers had recognised where services could be improved and various work streams were in place to mitigate and improve them.
- Staff understood their responsibilities to raise concerns and report incidents. Local sharing of learning arising from incidents had taken place.
- Cleaning audits showed consistently positive results.

Detailed findings

Safety performance

- The service did not use tools to demonstrate safety performance over time.

Incident reporting, learning and improvement

- Staff understood their responsibilities to raise concerns, record safety incidents, and near misses. We reviewed incidents between December 2016 and March 2017. During this period there were 61 incidents reported. These included patient related incidents, incidents reported due to crowding, and staffing shortages. There were also incidents reported for inappropriate referrals from the emergency department which meant that patients who were too ill for the urgent care centre were being sent there. There had been no never events within the service.

Requires improvement

Are services safe?

- We found that the service acted upon incident concerns and set clear actions on the incident reporting process. However, one member of staff said they did not always receive feedback from incidents they reported.
- There had been one serious incident reported which resulted in a patient's death. Although the incident itself was not attributable to the department, actions were put in place to update policies and process to action when a patient leaves the department without being seen. However, the action plans were limited and not robust. There was no indication of staff training being included or awareness being raised of the incident. There was no responsible individual for any actions made and no due dates.
- The due diligence process (a process to comprehensively appraise the quality of a service) had recognised that information on reporting was not escalated to the appropriate oversight groups and that processes for gaining assurance around actions and their progress was not embedded at a strategic level. Reporting did not receive suitable scrutiny or follow up outside of the service. Processes were being established during this inspection to ensure oversight and escalation of incidents where necessary.
- Since the takeover of the service by Great Western Hospitals NHS Trust there had been an increase in staff training in the incident reporting process and in root cause analysis. Senior staff within the urgent care centre attended a workshop led by Great Western Hospital's governance director and additional training had been delivered subsequent to that. There were also detailed transition plans in place for the transfer to Great Western Hospital's systems and processes and the introduction of a quality dashboard and an incident learning group.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- In the one serious incident that was identified as meeting this criteria there was evidence that duty of candour had been considered. All staff we spoke with were aware of the duty of candour and told inspectors they would apologise when something went wrong, regardless of whether the incident met the threshold.

Safeguarding

- Systems, processes and practices that are essential to keep people safe, were changing at the time of the inspection, as part of the transition from the previous organisation to Great Western Hospitals NHS Foundation Trust. At the time of the inspection the pre-existing provider safeguarding policy for adults is in force, but was under revision. The Children's policy had been replaced by the GWH policy.
- Not all staff had received suitable training in the safety systems, processes and practices to keep people safe from abuse. The Safeguarding Children's Standards produced by the Royal College of Emergency Medicine's (RCEM) Clinical Effectiveness Committee states that all emergency department medical and nursing staff should, as a minimum, have level two child protection training. Only 72% of staff had training in child protection level one and only 32% of staff had training in child protection level two and no one was trained to level three child protection Only 76% of staff had training in safeguarding adults level one. No staff were trained to level two.
- As part of due diligence, safeguarding training had been identified as an area for significant development, and a training programme was planned, agreed at the quality oversight group.
- The safeguarding lead for the previous organisation left in the early part of 2016 and no one was recruited to the role. A social worker had an oversight role and acted as a conduit for enquiries. This role was left vacant following the separation of the previous provider adult care services and the expertise and guidance was lost to community services. This meant that staff within the urgent care centre did not have expertise on safeguarding to refer too when issues arose.
- As part of the due diligence process the interim safeguarding lead for community services conducted an initial audit of safeguarding and reported to a quality oversight group in February 2017. The process found that data collection for safeguarding was very limited and there was no assurance regarding safeguarding referrals reported internally, over and above basic figures.

Requires improvement

Are services safe?

- From early March 2017, a single phone line was available for adult safeguarding support and guidance across the acute and community services, to enable improved reporting and capture of activity.
- Staff were aware of the processes in relation to safeguarding women and children at risk of female genital mutilation (FGM). There was a FGM training package being developed at the time of our inspection.

Medicines

- Arrangements for managing medicines did not always keep people safe. We found that the majority of medicines were kept on shelves and were stored in lockable containers. The room they were in was locked and was only accessible by electronic entry. However, other healthcare staff (including school nurses and community nurses who worked for other organisations) had access to this room. This meant that people whthout authorisation had access to medicines. Lockable medicine cabinets had been ordered, but the wrong ones were delivered and they were not fit for purpose. This was reported on the risk register and action was being taken to order more cabinets and put the highest risk medicines in the cabinets.
- During our inspection we found that medicines which were to be used for more than one patient (such as liquid paracetamol), which should be used or disposed of within six months of opening, were not always marked to show when they were opened. We raised this with the urgent care centre manager who removed them straight away for disposal.
- Patient Group Directions (PGDs) were in use to allow nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. The pharmacy review conducted in January 2017 found that of the 34 PGD documents known to be in use, six had expired. These included Fusidic acid, Flucloxacillin, Nutrofurantoin, Chloramphenical, Ibuprofen and Paracetamol preps.
- The pharmacy review found that PGD's may not have been approved, therefore may not comply with national guidance from the Medicines and Healthcare products Regulatory Agency. The documents were produced electronically using an unprotected programme and had automatic signatures lifted from other documents. The guidance states that that "The final document must be securely protected and the signature cannot be lifted out". As a result of this finding swift action was taken to resolve the issues and the management of PGDs was aligned with the trust's policy.

Environment and equipment

- The urgent care centre was designed and maintained to keep people safe. There was a designated waiting area with consultation rooms off of this. The main reception had lines of sight to most of these areas and there was close circuit television for all other areas. All rooms were equipped with call bells and staff knew the processes involved if one was activated.
- All equipment we checked was within its service date and this was managed by the estates team within the trust. All equipment and the premises were maintained by the estates team and they attended quickly if there were any problems or issues which made the area unsafe.
- In some of the consulting rooms there were doors adjoining them. Inspectors were able to overhear conversations with patients in other rooms which compromised confidentiality.
- The service had a children's waiting area. However, this was easily accessible by adults and was overlooked by the adults' waiting area. This was not in accordance with design guidance set out in Health Building Note 15-01: Accident and emergency departments (April 2013) recommends that the children's waiting area "should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the children waiting."
- The urgent care centre did not have a resuscitation trolley; however, there was an emergency crash bag. This bag was checked and if additional equipment was needed a resuscitation trolley could obtained from ambulatory care which was adjacent to the urgent care centre.

Quality of records

- Patients' records were stored electronically on a secure computer system. Staff had to ensure that all computer records were completed before they could move onto the next page. This included medical history, allergies and safeguarding assessments.

Requires improvement

Are services safe?

- Implementation of systems and processes was not effectively monitored and improved where required. The last records audit done in April 2016 sampled very few records. Only three staff were assessed as part of this audit.
- Compliance with records keeping standards was mixed. Of the 15 patient records reviewed: six did not use appropriate scoring or assessment tools; six did not have appropriate assessment recorded; eight did not evidence appropriate diagnosis; two did not have evidence of a treatment plan.
- There was no mechanism to assess improvements or to re-audit areas of non-compliance. Feedback was given to staff that had been assessed.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare associated infection. However, the infection prevention and control policy produced by the previous provider was under review at the time of the inspection.
- Only 12 out of 18 staff (67%) had received infection control training However, staff adhered to National Institute of Health and Care Excellence quality standard 61 statement three which states that people should receive healthcare from a healthcare worker who has decontaminated their hands both immediately before and after every episode of direct care. We found that there were alcohol gel dispensers throughout the unit and we saw staff always washing their hands before and after patient contact.
- Implementation of safety systems processes and practices were monitored using an audit methodology (as part of an annual work programme) which was consistent between all adult community services. As a result of the transition from an independent health provider to Great Western Hospital NHS Foundation Trust monthly reporting on these audits had commenced into the Quality Oversight Group via a quality dashboard.
- Compliance of staff in the urgent care centre with hand hygiene standards was 90% in the first three months of 2017. This was an improvement from an average of 81% in 2016.
- Cleaning standards were regularly audited. Despite audit results being positive we found some area where cleaning standards had not been met. For example we found high and low level dust and dusty drawers.

Mandatory training

- Not all staff were up-to-date with mandatory training in the safety systems processes. Of the 25 mandatory subjects the urgent care centre was only above the trust's target compliance rate of 80% for five of them. These included equality and diversity, infection control, information governance, information governance refresher training and moving patients training. Compliance for the remaining training varied between 32% and 76%. This included basic conflict resolution (66%), manual handling theory (53%), fire training (73%) and PREVENT counter terrorism training (48%). This meant that staff were not up to date with the latest best practice and advice to keep themselves or patients safe.

Assessing and responding to patient risk

- The department used a triage nurse to assess the patients when they arrived to assess for serious injuries. This included a National Early Warning Score assessment to identify patients who were sickest. This meant that when there were long waits to see an advanced practitioner, patients at highest risk could be seen first. When the triage nurse was either off sick or on annual leave a healthcare assistant ensured these assessments were completed.
- There were no target times for these assessments to be completed. However, we were told that when the computer systems are aligned with that of the emergency department they would be assessed by the fifteen minute target.
- There had been additional training delivered for the management and care of patients who were suspected of having sepsis (a life threatening infection). Staff knew what the processes were and could show inspectors where to find the policy. Sepsis was identified through the assessment tools on the computer system and this were audited as part of the notes audits.
- We were told about an incident where security had refused to go to the urgent care centre to support a lone working member of staff who was managing an

aggressive patient. However, processes had been put in place to prevent this from happening again. This new process had been tested recently and found that security attended the department quickly.

Staffing levels and caseload

- Staffing levels, skill mix, and caseload planning was considered and reviewed to ensure that patients received safe care and treatment at all times. Staffing was increased to reflect predictable influxes of patients. In January 2017 (the most recent data available) there were no vacancies for either registered or non-registered nurses and there was no usage of bank or agency workers.
- Sickness rates were below 5% and were in line with the national average. In January 2017 turnover was only 8% which was better than the national average.
- There was anxiety about lone working out of hours including at night and over weekends. Weekends were always busy which made staff anxious. They felt that as lone workers the workload was too great and became unsafe as patients often deteriorated in the waiting rooms. This had been recognised by the organisation and rota changes had taken place to ensure there was sufficient staff during these times to keep people safe at times of high demand. This included additional triage nurses and support staff.

Managing anticipated risks

- Business continuity plans are processes which are created to prevent and recover from potential threats to the operation of a service. The urgent care centre had a business continuity plan which covered a variety of topics including the management of IT issues, loss of power or water, and staff sickness. However, it did not set out contingency arrangements for adverse weather, such as heavy snow, or seasonal fluctuations in demand.

Requires improvement

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 requires improvement for effective because:

- Processes, protocols and patient pathways were not in line with best practice legislation. There were many policies which were out of date, some of them being several years out of date. Policies included the liquid medicines management policy, and the intravenous therapy policy.
- Information about patient outcomes was not routinely collected. A programme of audit and a review of polices were being set up to ensure that evidence-based practice was being followed and best practice was regularly reviewed.
- Arrangements for referral to the urgent care centre were unclear and staff told inspectors that there were many inappropriate referrals to the centre which needed streaming to the emergency department.
- Computer systems did not effectively share information between the urgent care centre and the emergency department and the rest of the trust.

However:

- Managers had recognised where services could be improved and various work streams were in place rectify and improve concerns around medicines management, patient outcomes, audit and referrals.
- Staff held appropriate advanced qualifications and training to perform their role. Staff were given opportunities to develop and improve their skills.
- Staff worked well with other services, particularly ambulatory care, to ensure that treatment was effective.
- A computer system was used to collect and record all information in relation to patient attendances at the urgent care centre. This was linked with the systems used in GP practices to ensure transfer of information.

Detailed findings

Evidence based care and treatment

- Many processes, protocols and patient pathways were not in line with relevant and current evidence based guidance, standards, best practice and legislation. We found that there were overwhelming amounts of policies which the service was expected to use, with many of them being out of date. Policies which were out of date included the intravenous therapy policy, which expired in 2014, liquid management policy, which had expired in 2012, and the venous thromboembolism policy, which expired in 2009.
- The trust had identified this as a risk as part of their due diligence processes and action was being taken to resolve it. The quality and oversight group for the trust was supporting the review of clinical and quality associated policies with a programme over six months. The aim of this was to review all policies for their appropriateness and to align them with existing trust policies.
- A nominated lead was to be identified for each area to ensure that a review was undertaken by the right person, and there were to be timelines for completion and a reporting process to the quality oversight, the community board, and the trust level community review meetings.

Pain relief

- All patients were asked about pain control as part of their assessment with a nurse. Pain assessments were done using a pain score and were recorded on the computer system. Where pain was observed nurses had access to the appropriate medicines to control pain appropriately.
- One patient we observed was experiencing physical pain and discomfort. The staff responded to this quickly and compassionately.

Patient outcomes

- Information about the outcomes of patients' care and treatment was not collected or monitored, apart from national audits for clinical specialities.
- The urgent care centre had developed a wider clinical audit programme for compliance with National Institute for Health and Care Excellence. However, this ceased in

2015 as the audit lead left. There was no evidence that audit activity was discussed in a wider forum or reported at corporate level within the previous organisation.
- This had been identified by Great Western Hospitals NHS Foundation Trust as an area of weakness. The urgent care centre was going through the process of incorporating specific audits in the trust's organisational audit programme and was identifying which local, national and commissioning audits they needed to participate in and the priorities of each of these.

Competent staff

- During the inspection there was no training plan. A programme of work to establish a skills assessment was underway at the time of the inspection. The previous provider had budget to offer training. This process had identified that there were training needs around the management of paediatrics, which was being addressed through working with the children's wards in the hospital.
- Most nurses within the department held certificates or masters degrees in advanced care. This meant that staff had the skills to deliver care effectively. We were given an example where a band five nurse had been supported to develop and continually learn and were due to start a band seven position as a result.
- The urgent care centre had recognised that appraisal rates were a risk to the service and put processes in place to improve compliance. This had been steadily improving from 39% in October 2016 to 85% in March 2017. Staff also access to clinical supervision to allow them to reflect and discuss concerns.

Multi-disciplinary working and coordinated care pathways

- All staff were fully involved in the care process to ensure that patients received coordinated care and treatment. Handover of patients was coordinated between services to ensure all relevant information was transferred. Staff were able to make referrals to GP's to ensure that all information was transferred to primary care.
- Staff communicated effectively between services (such as the emergency department, ambulance service, and safeguarding teams) when there were concerns around safeguarding or child protection concerns.
- There was good multidisciplinary working between the urgent care centre and ambulatory care staff. One patient, who the urgent care centre staff had questions about, had their issues resolved by asking doctors in the ambulatory care unit for advice. The doctor offered to see the patient so the patient did not have to go elsewhere for a review.

Referral, transfer, discharge and transition

- There were clear processes in place to refer a patient from the urgent care centre to the emergency department and there had been simulation exercises to manage a patient effectively when they deteriorated in the urgent care centre. These exercises increased staff understanding of the process and ensured that patients were cared for appropriately.
- Arrangements for referral to the urgent care centre from the emergency department were unclear. There were many incidents reported of inappropriate referrals from the emergency department to the urgent care centre or by emergency ambulance service. These included: patients who required a consultant review, which was not available in the centre; patients who should have been on the sepsis pathway; and patients who were in severe pain. All of these were escalated to the emergency department and the urgent care centre requested feedback from the matron.

Access to information

- All information needed to deliver effective care and treatment was available to staff through a computer system. There was no use of paper records so all information was accessible in a timely way. This included care and risk assessments, care plans and case notes.
- However, when people moved between services and teams through Great Western Hospitals NHS Trust it became more difficult to share information. The computer system within the urgent care centre did not share connectivity with that of the trust which made tracking patients difficult.
- The trust's due diligence review identified challenges with using the system. They were told by staff that the system was introduced by the previous provider at short notice with limited training and that it didn't necessarily meet the needs of the staff.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Requires improvement

Are services effective?

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Act 1989 and 2004. Staff were clear on their responsibilities and could give detailed responses about how capacity was assessed and how practices would change if a patient lacked capacity.
- Any comments around mental capacity were recorded in patients' individual records saved on the computer system. However, this was not audited by the centre so there was no assurance that staff followed processes correctly.

Good

Are services caring?

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

Summary

We have rated this domain good because:

- Feedback from patients was positive about the way staff treated them.
- We observed interactions with patients and found that people were treated with dignity, respect and kindness.
- Patients were encouraged by staff to be partners in their care and they supported them to make decisions. Staff had the time to spend with patients to ensure they could fully listen to their concerns.
- Staff responded compassionately when people needed help.
- Confidentiality was respected at all times.
- Staff were considered to be kind and went the extra mile to ensure that anxieties were addressed.

Detailed findings

Compassionate care

- We observed interactions between staff and patients. Staff understood and respected patients' individual needs and took the time to interact with them in a respectful and considerate manner. All staff introduced themselves by name and role and gave patients their complete attention during assessments.
- Patients made many positive comments to inspectors. One patient told us "they put me at complete ease even when I was worked up" and "I could not have received better care". Another patient said "I have been here several times and the nurses are always brilliant, they are really friendly and helpful".
- As a social enterprise the previous independent health provider were not obliged to undertake the Friends & Family Test (FFT), but implemented a system called "Just one Change" which worked on a similar principle to FFT but asked for feedback on one change or improvement that could be considered. There was no robust system for using and reporting on this card system. As of 17 April 2017 the urgent care centre planned to start using the Friends & Family Test to align them with Great Western Hospitals NHS Foundation Trust, allowing feedback to be gathered in a more structured way.

Understanding and involvement of patients and those close to them

- We observed staff communicating with patients in a way they understood. One patient was confused and the nurse took the time to ensure that they were listened to fully and that concerns were acted upon. Staff were empathetic towards patients and ensured patients understood the relevant treatment options fully.
- Nurses were given time to ensure that patients in vulnerable circumstances understood what was going on and were clear of the treatment they were giving them
- Staff always asked patients if they had any more questions at the end of their appointment and were able to direct them to various sources of information. This also included encouraging a healthy lifestyle and wellbeing.

Emotional support

- We were given examples where patients had been given appropriate support and information to cope emotionally with their care, treatment or condition. Staff were described as "going the extra mile and providing special comfort when clients were anxious, troubled, in pain or in need of support".

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 domain as good because:

- Managers had recognised where services could be improved and various work streams were in place to mitigate and improve them including targets for patients and the complaints process.
- Patients were able to access treatment in a timely way. Patients were expected to be treated within four hours of arrival. This was being met between 96% and 100% of the time for both patients attending the unit directly and patients re-directed from the emergency department.
- Staff understood the reasonable adjustments needed to ensure vulnerable people were cared for appropriately and took the time to ensure they fully understood the options available to them.
- Equality and diversity was considered when planning and delivering the service. The urgent care centre was accessible by patients with a disability and chaperone and translation services were available.
- The complaints system was being brought in line with the trust's system to ensure that all learning could be taken from a complaint and shared appropriately.

However:

- Patients were sometimes inappropriately re-directed to the urgent care centre by the emergency department, NHS 111 and the ambulance service. However, this was not audited to evidence numbers.
- Due to the computer systems in the emergency department and the urgent care centre being different, there was no way to track how long a patient who had come from the emergency department had been waiting.
- Some patients did not have the waiting times explained to them, which left them uncertain as to why they were waiting.
- There was no specific system in place to manage complaints. Complaints were investigated; however, there was limited narrative on lessons learnt and actions.

Detailed findings

Planning and delivering services which meet people's needs

- The service delivered care which met the needs of its service users. However, there were no clear inclusion or exclusion criteria. Patients who were streamed to the urgent care centre from other organisations (such as the emergency department, NHS 111 service, or the ambulance service) were not always appropriate. We were told that patients were streamed to the service that, for example, was likely to need an X-ray which the staff could not arrange. This would increase the time patient would be in either the urgent care centre or the emergency department before they received a diagnosis. This was not audited by the centre.
- The facilities and premises were mostly appropriate for the services that were planned and delivered. There were various consultation rooms off a main waiting room. There was adequate seating in the waiting room at the time of our inspection when the department was quiet.
- We also found that there was access to a vending machine and suitable baby changing facilities.
- There was a waiting room for children, which was partitioned from the adults' waiting room. This room had a selection of toys within the waiting area and a light up disco ball. The unit had received positive feedback from both patients and their parents about the waiting room which provided a calming environment for children. This area was covered by CCTV cameras which allowed staff to observe it at all times.

Equality and diversity

- Premises were designed and equipped so that disabled people could access the service on an equal basis to others. The waiting area and consultation rooms were big enough for wheelchair access and the receptionist, who checked in patients, would alert nurses if there was a problem with access.
- There was access to disabled parking. There was an ambulance and patient drop off area directly outside the unit and a ramp to the automatic doors, ensuring easy access for everyone.

Good

Are services responsive to people's needs?

- There was information displayed advising patients that they could request a chaperone during their consultation. Patients were asked prior to any intimate examination if they wished to make use of the chaperone policy. We observed patients who did not understand what this was had it explained to them clearly.
- Staff discussed with inspectors the use of translation services and told us that a telephone service was available for patients who could not speak English. One member of staff said they would use this service over using a family member or relative of the patient. There were no posters in the waiting rooms to publicise this service.

Meeting the needs of people in vulnerable circumstances

- National Institute for Health and Care Excellence statement nine states that patient should experience care that is tailored for their personal preferences. Staff made changes in how they communicated with patients to deliver care that took account of patients' complex needs, for example, those living with dementia or with a learning disability. One nurse we spoke with said that this flexibility allowed them to care for their patients appropriately rather than rush through an appointment.
- Staff had not received training in the management of dementia or learning disability. However, staff could tell inspectors how they would change their working style to suit the patient's needs.
- If a patient presented from their GP there was flagging systems in place to alert staff if a patient was living with a learning disability or dementia before they were assessed.
- The environment was not equipped to manage patients with dementia. There were no separate waiting areas for patients who may be anxious or agitated and there were no dementia friendly consultation rooms within the unit.

Access to the right care at the right time

- Patients received care and treatment in a timely way. The unit was subject to a commissioner agreed four hour target for time in the department for both patients presenting to the urgent care centre and those referred from the emergency department. Between November 2016 and March 2017 over 96% of patients seen within this target. Of the 27,467 patients seen in this time only 187 were seen over four hours.
- However, we were told by staff in the urgent care centre and staff in the emergency department that those that were re-directed from the emergency department (4,777 patients in total between November 2016 and March 2017) would have been subject to a separate four hour target. This meant that patients could be waiting in the emergency department for just under four hours, then the urgent care centre for just under four hours and not flag as a breach in any targets. There was no way to identify how many patients this affected as the computer systems between the services were not linked.
- Despite the four hour target being met, many patients commented about the long waits in the department. Of the 10 comment cards we received, six of them had commented on the waiting times, although did not indicate how long they had been waiting. Patients seemed to be confused about the waiting times and raised concerns that some patients were being seen before them when they had been there a long time.

Learning from complaints and concerns

- There was no specific system used in the previous organisation for managing complaints. Complaints were logged onto a spreadsheet which helped support and manage the whole complaints process, from receipt to response. Reporting around complaints focused on numbers and locations, but contained no narrative, lessons learned or actions.
- The trust and the urgent care centre were aware that there were missed opportunities for learning and were taking steps to improve systems and processes. There was a move to a trust wide aligned system. Complaints were now logged onto the system used across GWH and reported via the community quality dashboard. Work was underway to provide local logins to the system, so management of complaints could be undertaken at service unit level. It was anticipated this work would be completed by the end of June 2017.
- There were leaflets available in the waiting room on how to make a complaint. These were obvious to patients and easily accessible.

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 domain as good because:

- Managers had recognised where services could be improved and various work streams were in place to mitigate and improve them.
- Governance and performance management processes were being proactively assessed and established as part of the transfer of services from an independent health provider to the trust.
- The urgent care centre used risk registers to identify where the biggest risks were and the department was taking steps to manage identified risks. The centre had set up a dashboard and governance processes in line with the trust's systems and was using them to monitor performance.
- Leaders in the urgent care centre had the knowledge, experience and skills to lead effectively and were well respected. The leadership within the unscheduled care division was also effective and had the skills needed to integrate the urgent care centre with the division.
- Despite the amount of change going on within the urgent care centre staff morale was positive. Staff felt respected, valued, and supported by their leadership team.

However:

- More could have been done to engage members of the public in the design and development of the service.

Detailed findings

Leadership of this service

- As of April 2017 the leadership of the urgent care centre was to be transferred to be managed by the trust's unscheduled care division to allow for closer integration of services between the urgent care centre and the emergency department. The leadership team within the unscheduled care division had the skills, knowledge, experience and integrity that they needed to lead effectively. Leaders understood fully the challenges to good quality care and were well respected by staff.
- The leadership team within the urgent care centre was comprised of a manager, a senior nurse and a GP. This team also had the knowledge, experience and skills needed to lead effectively. They understood what the challenges to good quality care were and were able to describe with clarity actions and processes which were in place as a result.
- Managers within the urgent care centre were well supported by the trust's governance team and felt this was a significant improvement from the previous organisation. We were told that "we went from an organisation where there was no structure to one which was well structured and supportive".
- Nurses within the urgent care centre respected their managers and felt they could be open and honest with them if any concerns arose.

Service vision and strategy

- There was no written service vision or strategy document at the time of the inspection. This was due to the change in services and the integration with Great Western Hospitals NHS Foundation Trust. There were plans to develop these and meetings were underway to plan out the future for the department.
- There were plans in place to align the urgent care centre within the unscheduled care division and integrating services with the emergency department. The senior teams within the emergency department was looking ahead to how integration would work between the Different services would work. Meetings had commenced several weeks before the inspection to discuss with commissioners how the services would work to achieve the 'Luton and Dunstable model' benchmark (with GP access at the front door of either an urgent care centre or the emergency department) as recommended by NHS England. We were also informed about plans to move the minors' area of the ED to the urgent care centre to increase capacity in the majors unit, which would have a positive impact on crowding in the emergency department.

Governance, risk management and quality measurement

Good

Are services well-led?

- The due diligence process completed by Great Western Hospitals NHS Foundation Trust identified that governance within the service was weak. There was limited information or evidence demonstrating clear governance systems. There was insufficient ownership of clinical quality at a senior level and reporting for quality, safety, risk and patient experience was undertaken in silos limiting the ability to see the bigger picture. However, systems had been established to start bringing a level of accountability and broader involvement to the decision making process. This had been by way of weekly operations meetings, weekly business partner (service leads) meetings, the Quality Oversight Group and the Community Board.
- At the time of the inspection the trust was working with the urgent care centre to fully embed it within the trust's governance framework and support systems. Systems had been identified and were being set up to ensure that escalation of concerns and performance was managed by the hospital. This included the creation of a quality dashboard to assess information around safety, effectiveness and patient experience information.
- The urgent care centre had worked with the trust to develop a risk register which had been set up since the caretaking process commenced. On this register were the nine biggest risks to the urgent care centre. Risks included the storage of medicines, the lack of audit, appraisal rates and the transfer of a patient to the emergency department. These risks had clearly assigned actions and responsible individuals for managing them.
- Separately to the risk register the service had a separate risk register for risks which were being mitigated but still posed a risk. This register included work-related stress and gaps in competency. Assurance was gained through this risk register and each item had a clear review date and a responsible person accountable for actions.

Culture within this service

- Staff felt uncertain about the future of the urgent care centre. The inspection was conducted at a time of change of processes and leadership within the organisation. Staff felt that they were unclear as to what was going to happen and were anxious about the direction the department would be going in. Managers were supporting them through this and said that most staff embraced this change with little disruption to the team. They said they were proud of how well they managed the change.

Public engagement

- Other than the use of 'just one change' forms there was no other engagement with the public around the service provided by the urgent care centre.

Staff engagement

- Prior to Great Western Hospitals NHS Trust taking over the management of the urgent care centre there was limited staff engagement. There were no staff meetings or clear ways to share information and get feedback. At the time of the inspection staff meetings had been introduced, which were well received by both staff and managers.
- As part of the transition of services from the previous provider to Great Western Hospitals NHS Foundation Trust there were open forums which all staff were invited to attend. This was led by the director of nursing and was an opportunity for staff to ask questions.
- The urgent care centre produced a detailed monthly newsletter which contained information on departmental news, department performance and updates on policies and procedures.

Innovation, improvement and sustainability

- There was limited innovation within the service as a result of the constraints from their contract and the limited support from the previous organisation. Managers told inspectors about ideas which they wanted to take forward but highlighted that there were other priorities at a time of transition.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. 18 (2) Persons employed by the service provider in the provision of a regulated activity must – (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Staff were not meeting mandatory training levels in the urgent care centre.