Hillingdon Urgent Care Centre

Quality Report

Greenbrook Healthcare
Pield Heath Road
Uxbridge
UB8 3NN
Tel: 01923 844201
Website: www.greenbrook.nhs.uk/urgentcare

Date of inspection visit: 17 March 2017
Date of publication: 17/05/2017

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hillingdon Urgent Care Centre on 17 March 2017. Overall the service is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff were open and transparent and fully committed to reporting incidents and near misses. The level and quality of incident reporting ensured a reliable picture of safety.
- Learning was based on a thorough analysis and investigation of any errors and incidents. Opportunities for learning from internal and external incidents were maximised.
- The centre had effective systems in place to manage risks to patient safety. The centre staff and managers gave high priority to safeguarding children and vulnerable adults from the risk of abuse.
- Staff were aware of current evidence based guidance. Staff had the skills and knowledge to deliver effective care and treatment.
- Patient feedback indicated that patients were treated with care and respect and were involved in decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The service was accessible 24 hours every day. Patient feedback was positive about the ease of using the service and time taken to receive treatment.
- The centre had adequate clinical facilities but the children's designated seating area was ineffective and patient confidentiality was compromised given the location of the clinical assessments. However, environmental improvements were in progress.
- There was a clear leadership structure and staff felt supported by management. The provider proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider and staff had a good understanding of the centre's performance against national and contractual targets. The provider worked with the clinical commissioning group and other health partners to improve the service.

The areas where the provider should make improvement are:

- The provider should develop a written role description for the local infection control lead for reference.

We saw several areas of outstanding practice:

- There was a holistic approach to assessing and delivering care. The urgent care centre used evidence based guidelines to support its 'streaming decisions' and prioritise patients on the basis of clinical urgency and need. There was a systematic programme of audit with some local discretion on clinical topic selection. The service used the weekly email 'blog' with staff to cascade learning back into the system. There was a focus on continuing improvement as the service worked to develop new and more effective local 'pathways' to services (such as the early pregnancy assessment unit).
- The service actively sought feedback from patients and took action as a result. This was a contractual requirement but we were impressed with the level of patient engagement and the high levels of patient satisfaction the service achieved.
- The staff team was committed to working collaboratively with hospital and community based colleagues and services (including the A&E department, specialties and safeguarding teams and primary care practices) to ensure patients received appropriately coordinated care. The service proactively shared learning from incidents and audits with stakeholders and was persistent in seeking coordinated solutions where appropriate.
- The urgent care centre staff recognised that some patients had longer term needs that were not best met in an urgent care setting. The 'health coordinators' initiative to direct patients to more appropriate services and support patient registration with primary care services had reduced the number of patients who attended the centre frequently. The urgent care centre was building on this work by developing better links with general practices.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The service is rated as good for providing safe services.

- The local and corporate teams had fostered an open reporting culture. Staff were committed to reporting incidents and near misses. There was an effective system in place for recording, reporting and learning from incidents and the level and quality of incident reporting ensured a reliable picture of safety.
- The service used opportunities to learn from incidents to support improvement. Learning was jointly reviewed with hospital colleagues where appropriate.
- When things went wrong patients were informed in keeping with the duty of candour. They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the incident. They were told about any actions to improve processes to prevent the same thing happening again.
- The centre gave high priority to safeguarding and worked with colleagues in the Hillingdon hospital to share information and agree actions. Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. All safeguarding referrals were actively tracked to ensure they had been followed up by the appropriate agency or service.
- The urgent care centre had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- The urgent care centre had adequate arrangements to respond to emergencies and major incidents. These included effective joint working with the hospital A&E department. They were persistent in seeking coordinated solutions where appropriate.

Are services effective?

Outstanding

The service is rated as outstanding for providing effective services.

- Managers had a detailed understanding of the centre's performance against national and contractual quality requirements and took action to improve.

Summary of findings

- Staff were aware of current evidence based guidance. National and local guidelines were built into the centre's treatment 'pathways' which were reviewed and updated.
- A programme of continuous case audits and prescribing reviews was in place, findings were used to monitor quality and to make improvements. Staff told us they had received helpful personalised feedback, for example on recording.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff. This was additional to the external NHS appraisals process for GPs.
- The staff team was committed to working collaboratively with hospital and community based colleagues and services (including the A&E department, specialties and safeguarding teams and primary care practices) to ensure patients received appropriately coordinated care.
- We saw evidence of good coordination and integration in both day to day working arrangements (for example, 'huddle' meetings) and more strategically, for example in the monthly governance meetings.

Are services caring?

Good

The service is rated as good for providing caring services.

- We saw that staff treated patients with kindness and respect, and maintained confidentiality in so far as possible given environmental constraints.
- The service received very positive patient feedback about the quality of the service.
- Patients who participated in the inspection described the staff as professional, kind and supportive. Patients told us they were given clear information and were involved in decisions about their care and treatment.
- Information was displayed for patients about key support groups and organisations.
- Staff were aware of patients' anxiety and emotional distress and provided effective reassurance.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

Summary of findings

- The centre's managers reviewed the needs of patients and engaged with the clinical commissioning group to secure improvements to services where these were identified.
- The service had adequate clinical facilities but had outgrown its space. This was being addressed as the centre and A&E department were due to relocate to a different part of the hospital with more space later in the year.
- The urgent care centre was open 24 hours a day and seven days a week. It was accessible to patients with mobility difficulties. There were disabled facilities, an induction hearing loop, translation services and baby changing facilities.
- Children were assessed as a priority and the service had designated children's seating although this area was too small to function effectively.
- Information about how to complain was available and easy to understand and evidence showed the service responded promptly and openly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The service is rated as good for being well-led.

- The urgent care centre had a clear purpose and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about their responsibilities.
- There was a clear leadership structure. The urgent care centre had policies and procedures to govern activity and held regular governance meetings.
- The centre had developed a strong safety culture and effective arrangements were in place to identify and monitor risks.
- Staff had received inductions, annual performance reviews and attended meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. The centre had systems to notify patients of any incidents meeting the duty of candour criteria and learned from incidents, accidents and alerts.
- The provider sought feedback from staff and patients and we saw examples where feedback had been acted on.
- There was a focus on continuous learning and improvement at all levels.

Summary of findings

What people who use the service say

The service received very positive feedback from patients. The service actively promoted the 'Friends and family' test, a short standardised questionnaire asking patients if they would recommend the service and also regularly ran its own feedback surveys.

As measured by the Friends and family test, 94% of patients would recommend the urgent care centre and only 2% would not recommend it. This was based on the responses of 6100 patients over the previous 10 months. The monthly scores were also consistently high over this period.

The results from the centre's own survey were based on 92 completed forms from 200 distributed (a response rate of 46%). These showed that:

- 99% of patients would recommend the service
- 99% of patients reported being treated with dignity and respect
- 97% of patients reported being satisfied with their consultation
- 100% of patients receiving a prescription said they were fully informed about the medicines they were prescribed
- 99% of patients said they were advised where to seek further help if required.

The centre had received a further 175 completed forms in the first two weeks of March which we reviewed. Of these, 166 (95%) were wholly positive, eight were positive but included suggestions for improvement and one was negative.

We also spoke with nine patients (and their family members) on the day of the inspection. Our interviews included times when the centre was very busy. All nine patients were positive about their experience. Patients told us the staff were kind, sensitive, professional and supportive. Patients also commented on the service being quicker than they were expecting, for example, a parent with a young child had been assessed and treated within half an hour. Patients told us they were well informed about any treatment or medicines and this included patients who were undergoing diagnostic tests.

More critical comments and suggestions for improvement tended to focus on the environment, for example, parking, signposting, the small size of the children's waiting area and difficulty in hearing when one's name was called.

Patients consistently said that overall, the centre provided an excellent service.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The provider should develop a written role description for the local infection control lead for reference.

Outstanding practice

We saw several areas of outstanding practice:

- There was a holistic approach to assessing and delivering care. The urgent care centre used evidence based guidelines to support its 'streaming decisions' and prioritise patients on the basis of clinical urgency and need. There was a systematic programme of audit with some local discretion on clinical topic selection. The service used the weekly email 'blog' with staff to cascade learning back into the system. There was a focus on continuing improvement as the service worked to develop new and more effective local 'pathways' to services (such as the early pregnancy assessment unit).

Summary of findings

- The service actively sought feedback from patients and took action as a result. This was a contractual requirement but we were impressed with the level of patient engagement and the high levels of patient satisfaction the service achieved.
- The staff team was committed to working collaboratively with hospital and community based colleagues and services (including the A&E department, specialties and safeguarding teams and primary care practices) to ensure patients received appropriately coordinated care. The service proactively shared learning from incidents and audits with stakeholders and was persistent in seeking coordinated solutions where appropriate.
- The urgent care centre staff recognised that some patients had longer term needs that were not best met in an urgent care setting. The 'health coordinators' initiative to direct patients to more appropriate services and support patient registration with primary care services had reduced the number of patients who attended the centre frequently. The urgent care centre was building on this work by developing better links with general practices.

Hillingdon Urgent Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector**.** The team included a GP specialist adviser, an expert by experience and a second CQC inspector.

Background to Hillingdon Urgent Care Centre

Hillingdon Urgent Care Centre serves Uxbridge and the surrounding areas of North West London. The service is co-located with the A&E department at the Hillingdon hospital in Uxbridge.

The centre is open 24 hours a day, seven days a week including public holidays. Patients attend on a walk-in basis. Patients can self-present or they may be directed to the service, for example by the NHS 111 or their own GP.

The urgent care centre serves as the main point of entry to the Hillingdon hospital A&E department. All ambulatory patients are assessed (a process known as 'streaming') at the urgent care centre and are then treated within the centre or directed to the A&E department depending on the severity of their condition. Urgent care centre staff can also refer patients directly to other hospital specialties, for example paediatrics, or request a psychiatric assessment. Alternatively, patients may be directed to another service if more appropriate, such as the patient's own GP. The urgent care centre is busy and sees 240 patients daily on average.

- The service is provided by Greenbrook Healthcare (Hounslow) Limited in consortium with London North West Healthcare NHS Trust. Greenbrook Healthcare (Hounslow) Limited is the registered provider. Greenbrook Healthcare provides a number of primary care services across England encompassing GP practices, urgent care centres and out of hours primary care services.

Hillingdon Urgent Care Centre is staffed by a clinical team of GPs (with enhanced training on urgent care), emergency practitioners and nurse practitioners. The staff team also includes administrative and reception staff. Most of the GPs and some of the receptionists working at the centre are Greenbrook Healthcare bank staff (that is, they are employees but work across the organisation's services as required or preferred). The nurse and emergency practitioners are employed by London North West Healthcare NHS Trust. (The service also routinely uses appropriately qualified agency GPs and emergency nurse practitioners to ensure the staff rota is filled.)

Local leadership is provided by the urgent care centre's lead GP, lead emergency care practitioner and service and administrative managers, all of whom are permanently based at the Hillingdon site. Greenbrook Healthcare has centralised governance systems in place and the provider's medical director, deputy medical director and central team provide additional clinical and managerial support and oversight.

Hillingdon Urgent Care Centre provides the regulated activities of diagnostic and screening procedures; and treatment of disease, disorder or injury.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We have not previously inspected this service.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the urgent care centre and asked other organisations including Hillingdon NHS Clinical Commissioning Group and NHS England to share what they knew. We carried out an announced visit on 17 March 2017.

During our visit we:

- Spoke with a range of staff including the medical director, the lead emergency practitioner, one of the GPs, an emergency practitioner, a receptionist, the patient champion, the service manager and the Quality and Governance manager.
- Observed how patients were greeted on arrival and spoke with nine patients (and their family members) who had received treatment at the urgent care centre.
- Observed a 'huddle' that is, a short, stand up meeting involving both urgent care and A&E staff, covering any issues arising during the shift.
- Inspected the facilities, equipment and premises.
- Reviewed a wide range of documentary evidence including the service contract, policies, written protocols and guidelines, recruitment and training records, the safeguarding logs, incident reports, audits, patient survey results and complaints, meeting notes, performance indicators and monitoring checks.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

Good

Are services safe?

Our findings

Safe track record and learning

The local and corporate teams encouraged an open culture of reporting and learning from incidents. The level and quality of incident reporting ensured a reliable picture of safety:

- Staff recorded incidents on a paper or electronic recording form. (Paper forms were subsequently transferred to the computer system.) Staff told us they would inform the manager or their shift lead of any incident or 'near miss' and ensure the incident was documented. We saw several examples of reported incidents during the previous 12 months. Incidents had been reported by GPs, practitioners and administrative staff.
- The centre used the 'Datix' electronic incident recording system. This supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff we spoke with were familiar with the duty of candour and their responsibility to be open with patients. We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received an explanation and a written apology and were told about actions taken to prevent any recurrence. A recent example had involved a patient who was out of the country when the centre staff discovered that their injury had not been fully diagnosed. The staff had located the patient and informed them of the full diagnosis, how to safely manage the injury while they were away and the follow-up required on their return.
- We reviewed safety records and patient safety alerts. The local team kept a log of all safety alerts and actions taken in response. Alerts were shared electronically with staff members working at the centre including bank staff. Any alerts or updates to guidelines of particular relevance to the delivery of urgent care were the focus of a wider programme of work led by the corporate team. For example, updated NICE guidelines on the management of sepsis in children resulted in changes to the operating protocols used within the centre (including the supporting IT) and a programme of update training for staff.
- We saw evidence that lessons were shared and action was taken to improve safety in the centre. Incidents were logged and discussed at the centre's monthly clinical governance meetings and reviewed by the corporate team. The first part of the clinical governance meeting was attended by one of the hospital's A&E consultants and consultants from other specialties which facilitated the review of shared incidents. The centre's lead GP, lead practitioner and service manager were responsible for leading local investigations, providing feedback to individual members of staff and implementing actions as appropriate.
- In the last year there had been 82 reported incidents. These had been analysed and included for example 12 referral issues, 24 clinical incidents and nine incidents involving aggressive or violent patients. We were told that the clinical governance committee did not close any incident until learning was shared and any agreed actions had been completed and documented. Learning was disseminated with staff through a weekly email bulletin known as the 'Friday blog'. We saw several examples of the Friday blog. All the staff we spoke with including bank staff said they received it and found it useful. The centre also kept copies in the treatment area and in the locum folders to ensure this information was available to agency staff.
- There were recent examples of improvement and learning from incidents. For example there had been a cleaning incident which led to the spillage of a hazardous chemical in the A&E department. The fumes from the spill affected the joint urgent care centre and A&E reception area. The investigation identified that communication between The Hillingdon Hospital NHS Trust and the urgent care centre in relation to hazardous and major incidents needed improvement. As a result the urgent care centre was allocated a mobile phone (kept in the reception) which was used by the trust to convey urgent information regarding such incidents.
- In another case, the centre had reviewed its 'pathway' for pregnant patients attending with hyperemesis (that is, severe vomiting) to ensure they were given appropriate priority. A different incident had involved a

change to the centre's chest pain 'pathway' so that these patients were now escorted to the A&E department by a member of staff. The centre recorded and learnt from 'near misses', for example, the manager identified that a GP allocated to work at the centre did not meet the required criteria and intervened before the GP started their shift.

- The Friday blog also included advice in relation to trends in incidents, for example, a recent issue discussed ways to engage aggressive patients and highlighted further training opportunities covering conflict resolution.

Overview of safety systems and processes

The centre had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- There were arrangements in place to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. The lead GP was the centre's designated clinical lead for adult and child safeguarding.
- Safeguarding policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Key contact details were also available in the treatment areas, cubicles and consultation rooms. Patient information about Childline was also displayed in cubicles and consultation rooms.
- Staff demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. The GPs, the emergency nurse practitioners and the emergency care practitioners were trained to child protection level three. Non clinical staff were trained to level two.
- The centre gave high priority to safeguarding children and vulnerable adults at risk of abuse. The service received lists of children and adults known to be at risk from the neighbouring local authorities which were updated every week. All patients were checked against the list on arrival. There were clear criteria for safeguarding referrals, for example delayed attendance, pregnancy in under 18s, children who were frequent attenders and any alleged assault.
- Additionally, the centre actively tracked all adult and child safeguarding referrals it made to ensure these had been followed up. The service also screened every paediatric attendance and every attendance by an adult known to be at risk to check that no additional safeguarding measures were needed. Centre staff attended a weekly safeguarding meeting with the Hillingdon hospital safeguarding teams and staff from the A&E department, orthopaedics, paediatrics and maternity specialties.
- Notices in the treatment areas, individual cubicles and treatment rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The service maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. The Hillingdon hospital cleaning team covered the urgent care centre and carried out scheduled cleaning and were also available on call if required.
- The lead emergency practitioner was the centre's lead for infection prevention and control. They told us they understood their responsibilities although they did not have a written role description for reference. The lead practitioner had received training and there was a clear escalation structure to raise infection control issues via the service managers. Technical advice and training was available from London North West Healthcare Trust's infection prevention and control team. Staff had received up to date training on infection prevention and control. This was also a mandatory element of the induction programme.
- The centre had comprehensive infection control policies in place covering for example, hand washing, the safe handling of 'sharps', spillages and waste disposal. The centre was well equipped with personal protective equipment, hand washing and waste disposal facilities and a 'dirty' utility room which we observed to be uncluttered and used appropriately.

Good

Are services safe?

- .The infection control lead carried out an annual infection control audit. The centre also carried out routine hand washing audits. All staff members' hand washing technique was observed across two shifts on a randomly selected day.
- The staff acted when risks to infection control were identified. For example, the lead emergency practitioner had requested antibacterial wipes to be installed in the nearest hospital toilets with baby changing facilities.

The arrangements for managing medicines, including emergency medicines and vaccines minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- The centre carried out regular prescribing audits to ensure prescribing was in line with best practice guidelines. For example, the centre routinely audited antibiotic prescribing to ensure good practice was sustained.
- Blank prescription paper was securely stored and had to be signed out by the prescribing clinicians. All prescriptions could be tracked against individual clinician and patient codes.
- Patient group directions (PGDs) had been adopted to allow the nurse practitioners to administer medicines, for example tetanus vaccination in line with legislation. (PGDs are instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- Hillingdon hospital pharmacy managed the stock of emergency medicines supplied to the A&E department and the urgent care centre and carried out regular stocktaking and deliveries.

Recruitment checks were carried out by the urgent care centre management team with support from the centrally-based human resources department. We reviewed four personnel files (for two administrative staff and two GPs) and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body, indemnity insurance and the appropriate checks through the Disclosure and Barring Service. The provider had systems in place to assure itself that locum clinicians secured through an agency also had the necessary qualifications, registration and checks in place.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- Greenbrook Healthcare maintained a risk register for the centre which was reviewed by the clinical governance committee and the board. This included financial, business-related, operating and clinical risks and mitigating actions.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There were health and safety policies and protocols in place with named leads. The premises were managed by the Hillingdon Hospital NHS trust. We were able to inspect various risk assessments, insurance and maintenance certificates and labelling. We were told that the centre enjoyed a positive working relationship with the premises and facilities teams at the hospital and repairs were carried out promptly.
- Appropriate risk assessments had been carried out including a fire risk assessment. Fire alarms were tested weekly and all staff were trained on fire safety with a number of staff designated fire marshals. There was clear information and signage throughout the waiting area and centre for staff and patients on what to do in the event of a fire and how to exit the building. However, the centre had not carried out or been actively involved in any fire drill over the last 12 months. We were told this was because it was the hospital's policy to not run drills which risked compromising patient care.
- All electrical and clinical equipment was checked and labelled to ensure it was safe to use and working properly. Regular water sampling was carried out as recommended to monitor the risk of Legionella (Legionella is a type of bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff needed to meet patients' needs. Patient demand was modelled on an hourly basis allowing the provider to predict likely surges in demand with reasonable accuracy. There was

a rota system in place to ensure enough staff were on duty with the appropriate skill mix. The provider had a bank of regular locums who could cover planned or unplanned GP leave. Appropriately qualified agency locum GP and emergency nurse practitioners were also used to maintain the rota. Staffing levels were discussed in the monthly internal operations meeting. All the staff we spoke with said the centre had sufficient staff to meet patients' needs.

Arrangements to deal with emergencies and major incidents

The service had arrangements in place to respond to emergencies and major incidents.

- Staff received annual basic life support training. Some staff members, for example emergency care practitioners, were trained in advanced life support.
- The service had a defibrillator available on the premises, piped oxygen and a portable oxygen cylinder with adult and child masks. A first aid kit and accident book were also available.
- The urgent care centre worked closely with the A&E department when responding to medical emergencies. The urgent care centre staff called the A&E crash team and trolley if required. Staff we spoke with were experienced in handling these situations and knew the protocol. The centre treated all emergencies as reportable incidents and these were documented and reviewed for any learning.
- Emergency medicines were easily accessible to staff in a secure area of the service and all staff knew of their location. All the medicines we checked were in date and stored securely. The urgent care centre relied on certain medicines being available in the A&E department. This was generally efficient practice as the two services were co-located.
- The centre had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The reception was equipped with a folder with all the information staff needed to run the service safely in the event of a computer systems failure. Security staff were available on call. The receptionist carried a dedicated mobile phone as part of the hospital's alerting cascade in the event of a major incident.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- All ambulatory patients presenting at the hospital requiring urgent attention were booked in at the urgent care centre reception. (The reception staff were trained to identify and immediately prioritise patients with high risk symptoms, such as chest pain, shortness of breath or severe blood loss.)
- Patients were then assessed by a designated emergency nurse practitioner who determined the appropriate 'stream' for the patient with the support of a computerised patient management system. This process was known as 'streaming'. Patients with major or more severe conditions were streamed to the A&E department and patients with minor illness or injury were streamed to the urgent care centre.
- There were systems in place to keep all clinical staff up to date with guidance and standards including a programme of training updates. For example, the emergency nurse practitioners had attended study days covering paediatric urgent care. Staff we spoke with demonstrated that they could access guidelines from NICE and the local medicines formulary which they used when delivering care and treatment.
- The urgent care centre used operating protocols or 'pathways' which were evidence based. For example, the centre had incorporated the 'Canadian C-spine rule' in its protocol to determine if radiography was indicated following an injury. The corporate team took the lead for reviewing new or updated NICE guidelines with particular relevance to urgent care. For example, the operating protocols for the management of sepsis in children had been systematically reviewed and updated following changes to NICE guidance and supported with a programme of update training for staff.

Management, monitoring and improving outcomes for people

The urgent care centre was contractually required to meet a range of quality and performance indicators and provide bi-monthly performance reports to the clinical commissioning group. It was meeting most of its key performance indicators while experiencing increasing demand in 2016.

- The centre aimed to stream at least 98% of children within 15 minutes of arrival and 98% of adults within 20 minutes. Over the previous 12 months, the centre had consistently achieved the 20 minute target for adults and the 15 minute handover for ambulance handovers. However, it had tended to underachieve the 15 minute target for the assessment of children. Monthly performance on this indicator varied from 92% to 99% over the previous 12 months. We were told the provider attended regular contract meetings with the CCG to review further opportunities for streaming improvements. The centre treated individual cases where patients waited significantly longer than the target as incidents.
- The urgent care centre contributed to the Hillingdon hospital A&E department's performance on the national target on time from ambulance handover to initial assessment. The urgent care centre had assessed over 98% of patients attending by ambulance within 15 minutes of handover every month for the last six months.
- The urgent care centre rarely breached the national four hour target for assessment, treatment and discharge. The centre consistently achieved monthly performance of over 99% on this indicator. The centre staff were also aware that delayed referrals from the centre to A&E would negatively impact on the A&E department's performance. The centre's monthly referral rate to A&E (of patients initially streamed to the urgent care centre) was consistently below 10% and the majority of these patients (typically more than 75%) were referred within two hours of arrival. The centre and the A&E department jointly reviewed significant breaches involving referral to identify areas for improvement.
- The centre's performance on unplanned repeat attendance and redirection of suitable patients to their own GPs had proved challenging and the centre had not met its targets in these areas. The centre had successfully diverted around 2% of patients to primary care services each month over the last 12 months against a target of 3%. In response, the centre had employed a 'patient champion' who led a team of

'health connectors', that is workers who could advise patients on how to register with a GP, and who helped patients already registered with a GP to book an appointment. The project had not been formally evaluated but the managers told us that the number of patients who were classed as frequent attenders had fallen in recent months.

- The North West London clinical commissioning groups commissioned four urgent care services (co-located with A&E departments) across the area and collected some common performance data, including the 'time to stream' targets for children and adults. Hillingdon Urgent Care Centre scored comparatively well against this benchmarking in 2016/17.

The centre carried out a rolling programme of audits. In 2016, this included:

- Monthly audits of x-ray imaging, quarterly clinical notes reviews and quarterly audits of streaming, referrals to A&E, the management of frequent attenders and antibiotic prescribing. The centre also carried out an annual audit of safeguarding referrals. These were ongoing audits enabling the centre to monitor that improvements were sustained and embedded into practice. For example, the audit of frequent attenders completed in October 2016 showed that 44 patients had attended four or more times in the last three months. This was a marked improvement over the previous quarter when 109 patients had attended frequently and reflected the impact of the 'health connectors' initiative to support suitable patients to attend their usual GP or other community health services.
- The clinicians we spoke with confirmed that they received useful individual feedback. For example, the centre's rate of referrals to the A&E department had increased in 2016. The most recent audit of referrals (March 2017) showed marked variation in the rate of referrals between different clinicians. The lead GP shared the anonymised results with the staff and provided individual feedback to each referring clinician.
- The centre also conducted condition-specific clinical audits and there was local flexibility about the choice of topics. For example, the centre had recently audited its management of asthma (60 cases).
- All audits were presented at the monthly clinical governance committee and the results shared with the clinical commissioning group and in the 'Friday blog' (the weekly email update to staff).

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had a comprehensive induction programme for newly appointed members of staff and an induction pack for locum staff. The induction covered topics such as safeguarding, infection control, fire safety, health and safety and confidentiality. The induction programme was tailored to reflect specific roles to ensure that the GPs, emergency nurse and emergency care practitioners and non-clinical staff were fully prepared. For example, the service manager had visited the corporate teams, the provider's other services and had spent a week shadowing at Hillingdon Urgent Care Centre before formally starting in their role.
- Staff with specific roles were given appropriate training and guidance. For example, the emergency nurse and emergency care practitioners who carried out streaming completed additional training and a competency based assessment before being allowed to work in this role.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. The advance nurse practitioners and emergency practitioners had access to continuing professional education and support, including educational meetings, events and clinical supervision through London North West Healthcare Trust.
- The learning needs of staff were identified through appraisals, meetings, audits and reviews of service development needs. All staff had received an individual appraisal within the last 12 months. This was additional to the national system of external GP appraisal and clinical revalidation for GPs and nurses. Staff members we spoke with said they found their appraisal meetings well-structured and helpful.
- The centre manager kept a record of staff training and reminded staff of updates and training opportunities via email or the 'Friday blog' (the weekly email update to staff).

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Mandatory staff training included: safeguarding children and vulnerable adults, fire safety, health and safety, basic life support, infection control and information governance. Mental capacity act training was incorporated into the safeguarding modules.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way, for example, through the centre's computerised clinical patient management system.

- Centre staff were able to access 'special patient notes' containing important information about patients from their usual GP. Special patient notes are a mechanism by which GPs can raise awareness about any of their patients who are more likely to access services out of hours, such as those nearing the end of life or with complex care needs.
- The urgent care centre clinicians had access to a shared healthcare record tab within the centre's electronic patient management system for patients registered with a Hillingdon GP who had given consent. The shared record provided real-time information with access to a live feed of data from the GP practice with information including details such as diagnoses, medications, adverse reactions and allergies.
- The service shared relevant information with other services in a timely way. The centre was required to send a report detailing each patient's attendance and treatment to the patient's GP by 8am the day following the consultation. The centre had achieved 100% compliance with this target over the previous 12 months. The service also aimed to share key information with school nurses
- The urgent care centre staff worked closely with the staff in A&E. These services were well integrated and most patients appeared to experience a seamless journey through the system. For example, we met several patients who had been sent by the GP or emergency nurse practitioner for x-ray imaging or other diagnostic tests (which were located within the A&E department) and had then completed their consultation and treatment back in the urgent care centre. Patients told us each step had been clearly explained and they had not experienced any undue delay or lack of coordination.
- The urgent care centre and A&E clinical teams held a 'huddle' during each shift that is a short, stand up meeting to discuss issues as they arose and monitor demand.
- The urgent care centre staff were able to directly refer patients to various hospital specialties such as orthopaedics and paediatrics and to call on the psychiatric liaison team if a patient required mental health assessment. Specialty consultants attended the first part of the urgent care centre's monthly clinical governance meeting.
- The urgent care centre was developing relationships with the local general practices to promote more appropriate patient use of NHS services.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. The urgent care centre did not carry out any clinical procedures requiring patients' written consent but sought verbal consent and recorded that this had been obtained.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, one of the GPs on duty would assess the patient's capacity and record the outcome of their assessment.
- The process for seeking consent was monitored through regular reviews of clinical notes.

Supporting patients to live healthier lives

- Patients typically attended the centre with acute episodes of minor illness or injuries requiring urgent attention. The staff we spoke with said that responding to the patient's presenting health problem was their priority but they took opportunities to advise patients on health, lifestyle and accident prevention when appropriate.
- Clinical staff asked patients about their smoking status when appropriate and could refer patients to attend smoking cessation services if patients expressed the wish to stop.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Some patients attended with exacerbations of longer term conditions or conditions which could readily be treated in general practice and some patients attending the centre were not registered with a GP. The centre aimed to direct these patients to services able to provide ongoing advice and treatment which would better meet their needs over the longer term. The urgent care centre used a team of 10 'health connectors' who assisted patients in registering with a local GP, accessing primary care appointments and community services and advised on when to use NHS 111. They also signposted suitable patients to local health related workshops and courses, such as 'healthy heart' and 'living with diabetes' workshops and first aid training for parents.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed the centre maintained a calm and friendly atmosphere throughout the day of our inspection including during busy periods. Members of staff were polite and treated patients with dignity and respect.

- The centre was equipped with individual consultation rooms and a number of curtained cubicles. Staff were mindful of patient confidentiality and tended to use the cubicles for patients with injuries and the rooms for patients experiencing illness or more sensitive problems.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- The emergency nurse practitioner responsible for 'streaming' patients sat behind a reception type desk which made it difficult to protect confidentiality. The urgent care centre was planned to move to a different part of the hospital later in the year. The move included the planned installation of a streaming 'pod' which would provide greater privacy.

The centre received positive patient feedback about the service. The centre regularly ran its own feedback surveys. The most recent analysed survey results were based on 92 completed forms and showed that:

- 99% of patients reported being treated with dignity and respect.
- 97% of patients reported being satisfied with their consultation.

The centre had recently run another survey and we reviewed the completed forms (175) which had been returned but not yet analysed by the centre. We also spoke with nine patients (and their family members) on the day of the inspection. The feedback from these sources was overwhelmingly positive about patients' experiences. The patients we spoke with described the staff as kind, sensitive, professional and supportive.

Care planning and involvement in decisions about care and treatment

Patients who participated in the inspection told us they felt involved in decision making about the care and treatment they received. Several patients we spoke with had undergone several diagnostic tests before discharge and said each step of the process had been well explained. They also said they had received good advice and information about their medical condition and what to do if they experienced continuing problems. The centre's most recent patient survey results showed that:

- 97% of patients felt they had enough time to ask questions about their care / treatment.
- 100% of patients receiving a prescription said they were fully informed about the medicines they were prescribed.
- 99% of patients said they were advised where to seek further help if required.

The service made use of facilities to support patient involvement in decisions:

- Translation services were available if required for patients who did not have English as a first language.
- The service had a hearing loop at reception. One patient told us they found the centre's method of calling patients by name problematic as there was significant background noise when the centre was busy.
- Clinicians made use of special patient notes to support decisions about care and treatment.

Patient and carer support to cope emotionally with care and treatment

Notices in the centre's clinical area and individual consultation rooms and cubicles informed patients how to access a number of support groups and organisations. Patients particularly younger children sometimes arrived at the centre in a state of anxiety or distress. Parents we spoke with said the staff had been immediately reassuring and were able to positively engage children when providing treatment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service reviewed the needs of its local population and worked with the local clinical commissioning group (CCG) to secure improvements to services.

- The urgent care centre was clearly signposted around the hospital and from the car parks.
- The centre was accessible to patients with mobility difficulties. The centre's staff had access to a wheelchair stored in the A&E department if required. Staff assisted patients with mobility difficulties.
- The urgent care centre assisted when the A&E department was experiencing demand pressures. For example the urgent care centre and A&E department shared a waiting room. There was a process in place for the urgent care centre staff to monitor both A&E and urgent care centre patients and to assist should any of the A&E patients' health deteriorate while in the waiting room.
- There were disabled facilities and baby changing facilities available within the hospital. An induction hearing loop had been installed at the urgent care centre's reception area.
- Translation services were available for patients whose first language was not English.
- The urgent care centre was co-located with the A&E department at the Hillingdon hospital. It had adequate clinical facilities but improvements were needed (and in process) to protect patients' privacy and improve the 'streaming' environment. The few critical comments we received from patients during the inspection focused on environmental concerns.
- Children were assessed and treated as a priority and the service had a designated children's waiting area. However, this was too small for the numbers of children who used the centre at busy times. We were told this was being addressed as part of the centre's move and refurbishment later in the year.
- The provider took account of differing levels in demand in planning its service and adjusted staffing levels when demand was likely to increase for example, national holidays.
- The service was able to access the psychiatric liaison team. Patients in mental health crisis or experiencing more serious mental health problems were streamed as a priority to the A&E department.
- There were direct referral pathways in place to specialties other than the A&E department, for patients diagnosed with certain conditions or injuries.
- The managers and staff recognised that some patients' needs were better served by other services, such as local GP and community health services. The centre's team of 'health connectors' provided patients with help to register with a GP and they could book appointments for example with the patient's own GP or at the local primary care 'hub' service.
- The centre was usually able to accommodate any patient requests to see a clinician of the same gender, especially during normal working hours.
- Staff received training on equality and diversity and this formed part of the mandatory training updates for all staff.

Access to the service

The urgent care centre offered care for walk-in patients with minor illnesses and injuries that need urgent attention. Patients were able to access the urgent care centre directly by self-presenting. Some patients were also directed to the centre after contacting NHS 111 or by their own GP. (NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs). The centre was primarily funded for patients living in the borough of Hillingdon but there were no geographical restrictions on access. The centre was open to patients 24 hours a day, seven days a week including national holidays.

Patients attended on a walk-in basis and underwent a clinical assessment ('streaming'). Patients assessed as suitable for treatment in the urgent care centre, were 'streamed' to see an advance nurse practitioner, emergency care practitioner or GP.

Signage within the waiting area was sparse at the time of the inspection because this space was shared between the A&E department and urgent care centre and signs risked confusing patients. We were shown the prototypes of large new information boards which had been designed jointly by the urgent care centre and A&E department to inform

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients of the various patient 'routes' through the urgent and emergency care system so patients could understand for example, why some people were seen more quickly than others.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns. The centre's complaints policy and procedures were in line with recognised guidance and contractual obligations.

- The urgent care centre service manager was the designated responsible person who managed complaints about the service in line with the London North West Healthcare NHS Trust complaints policy and process. Investigations were carried out locally by the service manager, lead GP or lead emergency care practitioner and the response to the patient signed off by the deputy medical director. Complaints were analysed and reported to the centre's clinical governance committee, Greenbrook Healthcare's board meeting and the clinical commissioning group as part of routine contract monitoring.
- Information was displayed to help patients understand the complaints system. The centre provided complaints leaflets which clearly explained how to make a complaint and how to take it further if patients were unhappy with the urgent care centre's response. The leaflet also described other sources of available information or support including the NHS complaints advocacy service. The complaints leaflets could be requested in other languages or in Braille.
- The urgent care centre had received 29 complaints over the previous 12 months. Complaints had been appropriately handled, dealt with in a timely way and in line with the complaints policy. Patients were given a written apology and informed of the outcome and any actions taken as a result. Lessons were learnt from complaints and shared with staff, for example through the weekly 'Friday blog' email and action was taken to reduce the risk of recurrence and improve the service. For example, the introduction of new signage explaining the A&E and urgent care system had been triggered by patient complaints about perceived queue jumping.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The provider's vision for the service was to deliver high quality care and promote good outcomes for patients. The service was commissioned to form part of an integrated urgent care service for the population of Hillingdon and to take some of the demand pressures off the A&E department. We found that the urgent care centre appeared to be largely successful in achieving these aims.

- The service had an overall mission statement which was underpinned by a set of organisational values. These included putting the patient first; quality; integrity; learning and teamwork. Staff we spoke with were familiar with the values.
- The service had a strategy and supporting business plans to deliver the service in line with the vision, values and contract specification. The managers actively monitored the strategy and associated plans, risks and activity.
- The immediate strategic priority was premises improvements. We were told that the centre and A&E department were moving to a different part of the hospital later in 2017 as part of an ongoing hospital redesign and rebuilding programme. The managers had been involved in developing the specification of the new area and were confident the move would result in a better environment for patients and staff.

Governance arrangements

The service had a relatively complicated structure being provided by Greenbrook Healthcare and London North West Healthcare NHS Trust in partnership and hosted by the Hillingdon Hospital NHS Foundation Trust. However, the service had a clear overarching governance framework which supported the delivery of the strategy and good quality care. In practice, the managers and staff members understood the service structure and lines of accountability and there were effective processes for escalation, risk management and decision making.

Greenbrook Healthcare had a centrally based management team who supported effective clinical governance of the service. The medical director was the overall clinical governance lead. The deputy medical director and the Quality and Governance manager attended the service on a monthly basis and were regular members of the centre's clinical governance committee. The provider met bi-monthly with the clinical commissioning group as part of the regular contract monitoring process.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- The provider maintained a local risk register which identified potential barriers to the strategy and mitigating actions.
- Service specific policies were implemented and were available to all staff for reference. Where appropriate the service used London North West Healthcare NHS Trust policy to ensure consistency of practice and standards, for example in relation to the handling of patient complaints. The service also acted in line with relevant Hillingdon Hospital NHS Foundation Trust policies and procedures where appropriate, for example on fire safety. Policies were updated and reviewed regularly.
- The urgent care centre benefited from a strong safety culture. This included a focus on learning from incidents and high priority given to safeguard children and vulnerable adults from the risk of abuse.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the centre had effective infection control procedures in place and maintained these through regular internal audits.
- A comprehensive understanding of the performance of the service was maintained and was used to improve, for example incorporating updated guidelines on identifying and managing sepsis in children.
- We saw documented evidence, for example in the minutes of meetings and action plans which recorded shared learning and improvements to processes and practice, for example following incidents and audits.

Leadership and culture

On the day of inspection the managers, clinicians and staff members demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. The urgent care centre staff had an appropriate spread of skills and experience covering minor illness and injury. For example, GPs employed at the service were required to have enhanced training on urgent care. The

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

service was supported by centralised governance and management enabling the local staff to focus on the provision of clinical care. The service benefited from having local clinical leadership in the form of a lead GP and lead emergency care practitioner. When the leads were not on duty, the service had a 'shift lead' system to ensure that any urgent concerns, for example safeguarding or incidents would be escalated immediately.

Our discussions with staff and patients indicated that the vision and values were embedded in the culture and practice of the urgent care centre. For example, staff members told us they were committed to guiding patients to the right service for their needs in the longer term because they could see how this would benefit patients' health. One clinical member of staff told us that Greenbrook Healthcare genuinely cared about service quality and they were proud to work for the organisation.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We reviewed the incidents that had occurred in the previous 12 months and found that the urgent care centre had systems to ensure that when things went wrong with care and treatment:

- The urgent care centre gave affected people reasonable support, a clear explanation and a written apology.
- The service kept written records of verbal interactions as well as written correspondence.

Seeking and acting on feedback from patients, the public and staff

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The service participated the standardised NHS Friends and family questionnaire and ran its own patient feedback survey. Feedback was consistently positive. For example, the Friends and family results showed that 94% (of 6100) patients who provided feedback over the last 10 months would recommend the service.
- The provider reviewed feedback and took action to improve, for example collaborating with the A&E department to design new information signs for the waiting area.
- The provider obtained staff feedback through staff surveys, meetings (group and individual) and appraisals. Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt well supported with opportunities to develop professionally within the service and the wider organisation. There were relatively few staff meetings due to the use of bank and part time staff but staff told us the daily 'huddles' and the 'Friday blog' (the weekly email newsletter) were effective. The centre had recently introduced regular meetings for the reception team.
- We saw examples where the provider had responded in a timely way to issues raised by staff members. For example, the provider had secured agreement from the orthopaedics department that all referrals from the urgent care centre would be accepted. Staff were authorised to escalate any difficulties directly to the orthopaedic consultant on duty.

Continuous improvement

There was a focus on continuous learning, innovation and improvement at all levels within the service. New ways of working and ideas for improvement were discussed and implemented with the agreement of the clinical commissioning group.

- The provider had identified the recruitment of appropriately qualified GPs to be a risk to the sustainability of the service. It was exploring ways of encouraging doctors in training to experience placements in the centre and raise awareness of longer term employment opportunities in urgent care.
- The managers and staff were keen to explore improvements to the clinical pathways to improve patient experience, reduce pressure on the A&E department and meet their contractual performance targets. For example, they were developing a direct referral pathway from the urgent care centre to the hospital's early pregnancy assessment unit.
- The centre had found it difficult to meet its targets to redirect patients to alternative primary and community

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

health care services when appropriate. This had triggered the recruitment (via a voluntary organisation) of a team of health connectors who were trained to advise and support patients in accessing for example, appointments with their own GP. The connectors could also direct patients to relevant health related workshops and courses, for example first aid for parents.

- The lead GP and the service manager had attended the local GP practice federation and network meetings. The local team had initiated this work as they thought that joint working between the centre and local GPs would support behavioural change in some patients who attended the urgent care centre very frequently.
- Opportunities for learning from internal and external incidents were maximised. For example, learning was captured and shared in a regular summary sheet which was circulated across the company's primary and urgent care services.