Urgent Care Centre - Selby

Quality Report

The New Selby War Memorial Hospital,
Doncaster Road,
Selby,
North Yorkshire
YO8 9BX
Tel: 0300 1231 780
Website: www.yorkshiredoctorsurgentcare.nhs.uk

Date of inspection visit: 31/8/2017
Date of publication: 08/11/2017

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?	Good
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 the Urgent Care Centre - Selby on 31 August 2017. Overall the service is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Risks to patients were assessed and well managed.
- Patients' care needs were assessed and delivered in a timely way according to need. The service met the National Quality Requirements.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. Staff had access to and made use of e-learning training modules and in-house training.
- There was a system in place that enabled staff access to patient records. The out-of-hours staff provided other services, for example the local GP and hospital, with information following contact with patients as was appropriate.
- The service managed patients' care and treatment in a timely way.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider was aware of and complied 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).

However there was an area of practice where the provider needed to make improvements.

The provider should:

- Monitor that all staff are up to date with mandatory refresher training.

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.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective system in place for recording, reporting and learning from significant events.
- Lessons were shared to make sure action was taken to improve safety in the service.
- 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 event in the preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- There were systems in place to support staff undertaking home visits.
- The service had clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours.
- The Provider had developed a safeguarding strategy and a safeguarding network had been set up with safeguarding leads from all the regions across the Providers service. One of the clinical directors and the clinical support manager were completing level four safeguarding training at the time of the inspection. They were the Regional Named Professional and Service Safeguarding Lead for Yorkshire and would support the Providers Head of Safeguarding with the implementation of the strategy and on-going development of safeguarding activities.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The service is rated as good for providing effective services.

Summary of findings

- The service was consistently meeting National Quality Requirements (performance standards) for GP out-of-hours and urgent care services to ensure patient needs were met in a timely way.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for staff.
- Staff had access to and made use of e-learning training modules and in-house training. However it was not clear if all staff were up to date with mandatory training updates. In July 2017 the provider had centralised all the training and appraisal functions at the York regional office to enable them to monitor completion and highlight and address any gaps.
- Clinicians provided urgent care to walk-in patients based on current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from 29 of the 30 patients that completed our comment cards was very positive and feedback from the provider surveys was also very positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient confidentiality.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- Service staff reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.
- The service had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly 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 service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular meetings where governance issues were discussed.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The service proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the urgent care and out-of hour's service. Patient feedback was obtained by the provider on an ongoing basis and was included in their contract monitoring reports. Data was collected monthly by the provider. Results for the Urgent Care Centre – Selby (UCC) Out-of-hours Service for the period of February 2017 to July 2017 showed that patients were very positive about the service and the care they received, for example:

- In February 2017 nine patients responded;
  - 100% of patients surveyed said they would be likely or extremely likely to recommend the service to family or friends.
  - 100% said they felt reassured by the clinician.
  - 100% believed the clinician explained things well.
  - 100% felt the clinician understood why they were seeking help.
- In July 2017 18 patients responded:
  - 95% of patients surveyed said they would be likely or extremely likely to recommend the service to family or friends.
  - 92% said they felt reassured by the clinician.
  - 92% believed the clinician explained things well.
  - 94% felt the clinician understood why they were seeking help.

The provider also carried out a quarterly postal survey of patients that had attended the service. This survey was carried out jointly for patients who attended the UCC – Selby and the UCC – York. Results for July 2017 when 20 patients responded showed:

- 94% of patients felt the extent to which the clinician reassured them was good, very good or excellent.
- 100% of patients felt that the clinician's attitude was good, very good or excellent.
- 95% of patients felt the clinician's understanding of their reason for contacting the service was good, very good or excellent.
- 85% rated the clinician's explanation of things as good, very good or excellent.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards, 29 of which were positive about the standard of care received. Patients said staff were helpful, caring and polite and treated them with dignity and respect. They commented that staff were professional and explained things.

Areas for improvement

Action the service SHOULD take to improve

- Monitor that all staff are up to date with mandatory refresher training.

Urgent Care Centre - Selby

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a second CQC inspector.

Background to Urgent Care Centre - Selby

Urgent Care Centre (UCC) – Selby provides an Out-of-hours service through a contract with the Vale of York CCG to approximately 53,000 patients. Yorkshire Doctors Urgent Care (YDUC) which provides the service is part of a national organisation, Vocare Limited, which provides urgent care and Out-of-hours (OOHs) services to 10 million patients across the United Kingdom. YDUC also provide urgent care centres and/or OOHs services at York Hospital.

Patients can access the out-of-hours service from 6.30pm to 8am Monday to Friday and 24 hours throughout Saturday, Sunday and Bank Holidays. Calls to the out-of-hours service are handled by the NHS 111 telephone number. Patients are informed whether they will receive a telephone triage by the clinician in YDUC or face to face contact. The calls are passed directly to the YDUC system and appointments are directly booked for patients in the YDUC diary.

There is a Local Clinical Director for the UCC-Selby and the UCC-York and a stable clinical staff team. There is one full time GP and 10 part time GPs who work across the UCC –Selby and the UCC - York. There are two full time and one part time nurses who work across the UCC – Selby and the UCC – York. There are also 67 bank GPs and one bank nurse who work across the UCC – Selby and UCC – York (bank staff are GPs and nurses who are not employed permanently by YDUC but who are available to work as and when required). All of the clinicians, permanent and bank, will work across all the four centres covered by YDUC as and when required.

The service employs a number of both male and female GPs and nursing staff from the local community. The clinicians are supported by an administration / call handling team, receptionists, drivers and a management team who are responsible for the day to day running of the service.

The service supported the training of GP Registrars; doctors who are training to become GPs.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 31 August 2017. During our visit we:

- Visited Selby – Urgent Care Centre.

Detailed findings

- Spoke with a range of staff including the local clinical director, an advanced nurse practitioner, a receptionist and a driver.
- Inspected the premises and looked at cleanliness and the arrangements in place to manage infection control and equipment.
- Looked at the vehicles used to take clinicians to consultations in patients' homes, and reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients shared their views and experiences of the service.

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?

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the service manager of any incidents and there was a recording form available on the service's computer system. The incident recording form 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). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- The service carried out a thorough analysis of the significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes. If an audit was required as a result of a significant incident the audit plan and actions were included as part of the incident record.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, after a patient was directed to the GP Out-of-hours service by an urgent care practitioner when they should have been directed to the A/E department, YDUC – York discussed this with the NHS 111 service to minimise the risk of this recurring.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. 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. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurse practitioners were trained to child safeguarding level 3. The Provider had developed a safeguarding strategy and a safeguarding network had been set up with safeguarding leads from all the regions across the Providers services. One of the clinical directors and the clinical support manager were completing level four safeguarding training at the time of the inspection. They were the Regional Named Professional and Service Safeguarding Lead for Yorkshire and would support the Providers Head of Safeguarding with the implementation of the strategy and on-going development of safeguarding activities.
- The provider also produced a safeguarding newsletter. This included information on policies, training that different staff groups should complete and training dates, safeguarding network updates and examples of safeguarding incidents that occurred and lessons learned.
- Notices in the waiting room, clinical areas and on the provider website 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. There was an infection control lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits and monthly monitoring were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance e.g annual servicing of medicine refrigerators including calibration where relevant.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The service carried out regular medicines audits, with the support of the local CCG medicines management team, to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions (PGDs) were used by nurse and emergency care practitioners to supply or administer medicines without a prescription. PGDs in use had been ratified in accordance with national guidance. (PGDs are written instructions that have been produced in line with legal requirements and national guidance and contain specific criteria that nurses and paramedics must follow when administering certain medicines).
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. The provider held a Home Office licence to permit the possession of controlled drugs within the service. There were also appropriate arrangements in place for the destruction of controlled drugs.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out-of-hours vehicles.
- Arrangements were in place to ensure medicines and oxygen cylinders carried in the out-of-hours vehicles were stored appropriately.
- Arrangements were in place to monitor the temperature in cars to ensure medicines and oxygen cylinders were stored at the correct temperatures.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in areas accessible to all staff that identified local health and safety representatives. The service had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance. The service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- There were systems in place to ensure the safety of the out-of-hours vehicles. Checks were undertaken at the beginning of each shift. These checks included fuel, oil and water levels, tyre pressures and wind screen wipers. Records were kept of MOT and servicing requirements. The vehicles were also fitted with a global positioning system so that their speed and location could be tracked. This improved safety for drivers and clinicians, as the control room always knew where the cars were located. This could also be used to manage demand when required. We checked the vehicles and found that they had all necessary equipment and medicines.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand. We saw that the rotas had been planned until January 2018.
- Providers of urgent care and out-of-hours services are expected to meet a number of National Quality requirements (NQR). NQR 7 related to staffing: Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. They must

also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand. The provider had achieved 100% compliance with NQR 7 from July 2016 to July 2017.

Arrangements to deal with emergencies and major incidents

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

- There was an effective system to alert staff to any emergency.
- All staff received annual basic life support training, including use of an automated external defibrillator.
- The service had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- A first aid kit and accident book were available.
- The service had a comprehensive business continuity plan in place for major incidents such as flood, power failure or building damage. The plan included emergency contact numbers for staff.

Good

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 service guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The service monitored that these guidelines were followed.

Management, monitoring and improving outcomes for people

From 1 January 2005, all providers of out-of-hours services have been required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQRs are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group (CCG) on their performance against standards which includes audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality. The provider reported jointly to the CCG for the Urgent Care Centre – Selby and Urgent Care Centre – York.

We saw that between July 2016 to July 2017 the provider was meeting these requirements overall. For example:

NQR 4 - Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting CCG.

The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

The provider achieved 100% compliance for NQR 4 between July 2016 to July 2017 (target was 100%).

NQR 11: Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence.

The provider achieved 100% compliance for NQR 11 between July 2016 to July 2017 (target was 95%).

NQR 12: Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Urgent: Within two hours - The provider achieved 92% to 97% from July 2016 to July 2017 (target was 95%).
- Less urgent: Within two to six hours -. The provider achieved 94% to 99% from July 2016 to July 2017 (target was 95%).

There was evidence of quality improvement including clinical audit.

- An assurance framework was in place; annual audits were carried out and the provider had developed an audit plan for 2017/2018 outlining when audits would be completed and when re-audits would be done. Responsive audits were carried out where appropriate and improvements implemented and monitored where necessary. For example; an audit had been done to check if the service was compliant with national guidelines for antibiotic prescribing for patients with sore throats. There were a number of criteria in the audit that needed to be met and the service had identified where improvements were needed. One criterion showed that antibiotics had been prescribed appropriately in 51 of 60 cases. The service was planning to repeat the audit every three months to monitor further improvement. The provider had recently employed a GP who taken the lead for clinical audit and was allocated six hours per week to undertake this role.
- The service participated in local audits, national benchmarking, accreditation, peer review and research.
- The service regularly reviewed national studies and implemented improvements to services. Recent action taken included the development of a sepsis toolkit (sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs); clinical leaders had worked with specialists from secondary care, including paediatric consultants

and intensive care clinicians and had implemented a set of guidelines and information leaflets for staff and patients on how to recognise sepsis and ensure treatment is provided as soon as possible. The toolkit was accessible to all clinicians.

Effective staffing

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

- The service had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period.
- Clinical supervision processes were in place for the salaried GPs, nurses and paramedics which included reflective feedback and a review of their professional standards. A clinical supervision policy had recently been implemented; this set out expectations for clinicians and their supervisors that appraisals would be carried out annually.
- The performance of each clinician was audited regularly. This included reviews of face to face and telephone consultations for nurses and paramedics and telephone consultations for GPs – face to face consultation audits for GPs was due to be implemented. Outcomes were rated as either red flag alert, which meant all clinical work was ceased and the clinician was invited in to discuss the results further and reflect on their work; borderline; which meant the clinician could continue to work but were invited to reflect on their consultation and were audited again within three months; and proficient. Audits were carried out every three months or more frequently, depending on the clinician's results.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, training for telephone consultations included theory and practical training in clinical assessment. Practitioners who undertook this role were signed off as competent. The service demonstrated that staff working in the minor injuries unit and out-of-hours service had the relevant experience and skills to deliver the service. Staff had completed training in minor illnesses and minor injuries and had completed competency assessments. Bank staff also had relevant experience. Before booking any new bank staff the service asked for confirmation of their qualifications, references and training. The provider confirmed annual updates of statutory and mandatory training for bank staff.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. For example, after expressing an interest in medicines management one of the drivers had completed level 2 training in medicines management so they could support the pharmacy technician.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Staff had completed mandatory training either with YDUC or if they were bank staff with their main employer. However it was not clear if all staff were up to date with mandatory training. The provider was reviewing their training records to ensure all staff were up to date with mandatory training updates. We saw data for July 2017 and August 2017 which showed that the percentage of staff that had completed training was improving. For example:

- In July 2017 completion of infection prevention and control Level 1 was 61%; in August 2017 this had increased to 91%.
- In July 2017 completion of safeguarding children Level 2 was 45%; in August 2017 this had increased to 91%.

In April 2017 training had become a central function and a Head of Training has been appointed. The provider had centralised all their training and appraisal functions at the Maple House York regional office to enable them to monitor completion and highlight and address any gaps.

Monthly training sessions were provided for all clinical staff and they were provided with a monthly clinical bulletin which included several 'learning points'.

Coordinating patient care and information sharing

Good

Are services effective?

(for example, treatment is effective)

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- This included access to required 'special notes' and summary care records which detailed information provided by the person's GP. This helped the urgent care and out-of-hours staff in understanding a person's need. NQR 3 said: Providers must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness). The provider achieved 100% compliance for NQR 3 between July 2016 to July 2017 (target was 100%).
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked collaboratively with the NHS 111 providers in their area.
- The provider worked collaboratively with other services. If patients needed specialist care, the out-of-hours service, could refer to specialties within the hospital. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.
- The service was located within Selby Hospital which facilitated good working relationships between the services.

The service worked with other service providers to meet patients' needs and manage patients with complex needs. It sent out-of-hours notes to the registered GP services electronically by 8am the next morning.

NQR 2: Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data.

The provider achieved 100% compliance for NQR 2 between July 2016 to July 2017 (target was 95%).

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- 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 clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 30 comment cards of which 29 were positive about the standard of care received. Patients said staff were helpful, caring and polite and treated them with dignity and respect. They commented that staff were professional and explained things. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

NQR 5 stated; Providers must regularly audit a random sample of patients' experiences of the service (for example 1 per cent per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting CCG.

Providers must cooperate fully with CCGs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

The provider achieved 100% compliance for NQR 5 between July 2016 to July 2017 (target was 100%).

The provider asked patients who attended the UCC – Selby to complete feedback on an on-going basis. Results from this feedback was very positive for example:

- In February 2017 - nine patients responded;
  - 100% of patients surveyed said they would be likely or extremely likely to recommend the service to family or friends.
  - 100% said they felt reassured by the clinician.
  - 100% believed the clinician explained things well.
  - 100% felt the clinician understood why they were seeking help.
- In July 2017 - 18 patients responded:
  - 95% of patients surveyed said they would be likely or extremely likely to recommend the service to family or friends.
  - 92% said they felt reassured by the clinician.
  - 92% believed the clinician explained things well.
  - 94% felt the clinician understood why they were seeking help.

The provider also carried out a quarterly postal survey of patients that had attended the service. This survey was carried out jointly for patients who attended the UCC – Selby and the UCC – York. Results for July 2017 when 20 patients responded showed:

- 94% of patients felt the extent to which the clinician reassured them was good, very good or excellent.
- 100% of patients felt that the clinician's attitude was good, very good or excellent.
- 95% of patients felt the clinician's understanding of their reason for contacting the service was good, very good or excellent.
- 85% rated the clinician's explanation of things as good, very good or excellent.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

The provider asked patients who attended the UCC – Selby to complete feedback on an on-going basis. Results from this feedback was very positive, for example:

- In February 2017 - nine patients responded;
  - 100% believed the clinician explained things well.
  - 100% felt the clinician understood why they were seeking help.
- In July 2017 - 18 patients responded:
  - 92% believed the clinician explained things well.
  - 100% felt the clinician understood why they were seeking help.

Good

Are services caring?

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The provider had developed a translation file which contained common phrases used in the service to assist them in communicating with patients who did not speak English as a first language.
- Staff had access to the British Sign Language alphabet and could signpost patients to resources such as the signed videos on NHS Choices.
- Information leaflets were available in easy read formats.
- A hearing loop was available for people with a hearing impairment.

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 engaged with its commissioners to secure improvements to services where these were identified. Monitoring reviews and clinical governance meetings were regularly held. At the time of the inspection the provider was in discussions with the CCG and York Hospitals Foundation Trust about extending the urgent care service provision to 24 hours a day.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service.
- The provider supported other services at times of increased pressure, for example the emergency department at York Hospital.
- There were accessible facilities, a hearing loop and translation services were available.
- There were systems in place to monitor demand in real time. This meant work could be shared more effectively between clinicians, reducing waiting times for patients.

Access to the service

Patients could access the urgent care service 24 hours a day, 365 days a year and the out-of-hours service from 6.30pm to 8am Monday to Friday and 24 hours throughout Saturday, Sunday and Bank Holidays. Calls to the out-of-hours service were handled by the NHS 111 telephone number. Patients are informed whether they will receive a telephone triage by the clinician in YDUC or face to face contact. The calls are passed directly to the YDUC system and appointments are directly booked for patients in the YDUC diary.

There were arrangements in place so that staff caring for patients at the end of their life could contact the service directly, for example district nurses.

Feedback received from patients from the CQC comment cards, the provider's surveys and from the National Quality Requirements scores indicated that patients were seen in a timely way. The National Quality Requirements (NQR) scores indicated that for the previous five months patients were seen in a timely way (all the NQR indicators had been met).

Comments from the provider's own surveys undertaken in January 2017 and July 2017 showed patients were seen quickly and found the service very efficient.

The service had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

A triage clinician assessed all requests for face to face consultations. They telephoned the patient or carer to gather information to allow for an informed decision to be made on prioritisation according to clinical need.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service.
- We saw that information was available to help patients understand the complaints system. Leaflets detailing the process were available in the waiting rooms and there was information on the provider's website.

No complaints were received for UCC - Selby however learning from complaints from the provider's other locations was shared. We looked at a sample of complaints received in the last 12 months at UCC - York and found these were dealt with in a timely way and the provider was open and transparent when dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from analysis of trends. Action was taken as a result to improve the quality of care. For example, following a complaint which included comments that the clinician did not identify themselves and was not wearing their name badge, all clinicians were reminded in the YDUC newsletter to wear their name badges at all times.

NQR 6: Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting CCG. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The provider achieved 100% compliance for NQR 6 between July 2016 to July 2017 (target was 100%).

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

- The service had a mission statement which included delivering high quality services which were patient centred and used appropriate skill mixes and modern technological, administrative and management systems. Staff knew and understood the mission statement and values.
- The service had a robust strategy and supporting business plans that reflected the vision and values and were regularly monitored.

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.
- The provider had a good understanding of their performance against National Quality Requirements. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. A risk register was in place and this was monitored at the monthly Quality Reporting Meeting.

Leadership and culture

On the day of inspection the provider of the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care.

They told us they prioritised safe, high quality and compassionate care. Staff told us the managers and GPs were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place 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).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment:

- The service gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included a 'Clinician/Employee Information Folder' that was available which included patient survey results, updates on clinical guidelines and alerts and performance with the national quality requirements and a monthly newsletter with information on learning from incidents and complaints.
- The CCG GP practice newsletter was cascaded to staff to keep them up to date with initiatives in the local area. For example, the Diabetes Transformation Fund and a new telephone support line for patients experiencing a mental health crisis.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the providers. Staff had the opportunity to contribute to the development of the service.
- During operational hours staff had access to team leaders and on-call clinical support at all times.

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

Are services well-led?

Good

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

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 had gathered feedback from patients through surveys and complaints received.
- The service had gathered feedback from staff through a staff survey and through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run. For example, access to a piece of equipment was not possible if Trust staff were using the room so following a suggestion from staff this was moved to a secure area where staff could always access it.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.