City Health Care Partnership CIC

BD256

Urgent care services

Quality Report

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Date of inspection visit: 8 – 11 November 2016
Date of publication: 26/04/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-459758269	City Health Care Partnership CIC - Bilton Grange Health Centre		
1-286634785	City Health Care Partnership CIC - Bransholme Health Centre		
1-279570042	City Health Care Partnership CIC - The Freedom Centre		
1-279570366	City Health Care Partnership CIC - The Westbourne Centre		

This report describes our judgement of the quality of care provided within this core service by City Healthcare Partnership CIC. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by City Healthcare Partnership CIC and these are brought together to inform our overall judgement of City Healthcare Partnership CIC

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated urgent care services as good because:

- Patients received friendly, compassionate care and treatment which was well directed to meet their needs and access standards were consistently achieved.
- Patients presenting with high risks and deteriorating patients were identified and escalated appropriately. Staff understood their responsibility to safeguard patients. Staff followed consent procedures and evidence based guidance to ensure the effectiveness of treatment.
- Public and staff engagement was well developed and levels of patient satisfaction compared well with similar services nationally.
- Directors of the care group which included urgent care and senior managers of the service provided clear and reliable operational leadership. The culture was positive and patient focussed.
- Staff competence was supported through regular training, supervision and appraisal. Staff felt valued and supported by managers and were proud to work for the service. Staff were recognised for improvement and innovation.
- Staff were trained in incident reporting, encouraged to report incidents and learning was shared. Duty of candour was considered.
- Equality and diversity was reflected in delivering services. Facilities were designed for disabled access and patients with a learning disability were supported. An integrated urgent care service was being introduced in response to people's needs.
- Equipment was maintained and medicines were stored and administered safely. Infection control and hygiene procedures were followed and a high standard of cleanliness was maintained.
- Urgent care liaised effectively with other health services. Electronic patient records were easy for staff to use and were linked with primary care. A resilience and business continuity plan was in place for adverse events in collaboration with external organisations.
- The vision and strategy was embedded and governance, risk management and quality measurement were in place. Items identified for action were followed up. Although the service did not receive many complaints, they were investigated and learning was shared.

However

- The clinical audit programme required development.
- For one subject area, moving and handling, mandatory training was not fully completed but this was being addressed with a change of training provider.

Summary of findings

Background to the service

City Healthcare Partnership CIC provided urgent care services to adults and children in Hull and the East Riding of Yorkshire. Urgent care services operated within the organisation's care group one business unit.

Urgent care services included a nurse-led minor injuries service at Bransholme health centre, the Freedom Centre and Bridlington hospital. Urgent care was supported by GP out of hour's services at the Westbourne health centre and the Bilton Grange health centre, which we visited although Bilton Grange subsequently closed in November 2016. Bridlington hospital was inspected by CQC in July 2016 and was rated as good. Therefore, we did not visit Bridlington hospital at this inspection. The service also undertook home visits.

The organisation's key performance indicators showed that 39,744 patients attended the minor injury units in 2015-16.

Our inspection team

Chair: Helen Bellaires, Non-Executive Director

Head of Inspection: Amanda Stanford, Care Quality Commission

The inspection team included CQC inspectors and specialist advisors in urgent care.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew. We analysed both organisation-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 8 to 11 November 2016 and an unannounced visit on 22 November 2016.

We observed how people were being cared for and talked with patients and family members who shared their views and experiences of the care they had received. We reviewed care and treatment records of adults and children who used the services.

We visited services based at four locations and observed the care and treatment, reviewed the records and spoke with 20 patients and their relatives and carers. We accompanied staff during three home visits, listened in during telephone triage and during a major incident scenario enactment, and spoke with 25 members of staff including staff in a focus group.

For the purposes of the inspection, children treated in the urgent care centre or minor injuries unit were considered as part of this core service, not as part of children and young people's services.

Summary of findings

What people who use the provider say

Patients and their relatives and carers spoke positively about the care and treatment they received. Patients spoke about the convenience of the service and the relevance of the diagnosis they received. Patients felt supported and said the staff they met really cared about them. Patients told us they were happy with the service they received and said staff were friendly to them.

Patients and their relatives and carers told us they appreciated their assessment, care and treatment. They told us staff explained things to them really well so that they understood the relevance of the diagnosis and treatment they received. A patient who received emotional support told us that staff were really nice and listened to them.

Good practice

Outstanding practice

The quality of care and treatment provided was underpinned by the service's focus on the learning and development for staff, which was supported by commissioners. The advanced nurse practitioner role had been developed over the previous 12 months, with competencies extended to include both illness and injury.

Urgent care services developed a telephone triage interface to assess incoming calls. During the telephone triage call patients were prioritised based on their clinical need. If the patient deteriorated, the patient was reprioritised and seen more quickly. Telephone triage staff were supported by a clinical decision support system widely used in NHS settings. Patients presenting with high risks and deteriorating patients were identified and similar conditions were assessed consistently.

Urgent care services participated in a recently established falls response pilot scheme with the ambulance service, fire and rescue and other health services. Emergency care practitioners (ECPs) based in urgent care provided the clinical input and had trained ten fire officers involved in Hull FIRST. Where a clinical assessment or medical treatment was needed following a fall, ECPs worked with other clinicians at the patient's home or at the scene of the fall incident to help avoid unnecessary transfer to hospital.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should develop its clinical audit programme to measure quality of care.
- The provider should ensure staff have completed training in moving and handling.
- The provider should use engaged signs to indicate when consultation rooms are occupied to support patient privacy.
- The provider should consider using a hoist to assist with the moving and handling of patients with mobility difficulties.

City Health Care Partnership CIC

Urgent care services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as Good because:

- Patient risk was assessed and escalated appropriately. Patients presenting with high risks and deteriorating patients were identified.
- No never events or serious incidents had been reported in urgent care services, although incidents that did occur were readily reported.
- Staff were trained in incident reporting, encouraged to report incidents and learning was shared. Duty of candour was considered and followed appropriately.
- Staff understood their safeguarding responsibilities and patients at risk were identified.
- Patient records were fully maintained electronically, were easy for staff to use and linked with primary care settings.
- Medicines were stored and administered safely.
- Equipment was suitably maintained and the environment was being extended for integrated urgent care services.
- Cleanliness, infection control and hygiene procedures were maintained to a high standard.
- There were enough skilled staff available within urgent care services; there was just one vacancy at the time of inspection.
- Urgent care services maintained a resilience and business continuity plan and contributed to the local resilience plan which enabled the service to respond appropriately to adverse events.
- Staff had completed their mandatory training (with the exception of one subject area).

However,

- Only 61% of clinical staff had completed moving and handling training at the time of inspection, but the service was taking steps to address this.
- The consultation rooms did not have an engaged sign to show when the room was occupied.

Detailed findings

Safety performance

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. No never events had been reported in urgent care services.
- There were no serious incidents reported for urgent care services.

Good

Are services safe?

Incident reporting, learning and improvement

- Incidents were reported using an electronic reporting system also widely used in the NHS. Data the organisation provided showed that 22 incidents were reported in urgent care services, which occurred between April and September 2016. Incidents were categorised according to type of incident and represented a variety of causes. The most frequently occurring category was security, with five incidents.
- Staff in a focus group informed us that they were encouraged to report incidents. Staff were trained in use of the incident reporting system and encouraged to use the system but few reportable incidents occurred in urgent care services. Staff informed us that learning was shared through global email or bulletins, for example the medicines bulletin. They said things that needed addressing were dealt with quickly.
- A quality and integrated governance report was prepared monthly which included an overview of incidents that had occurred in the service. Incidents were graded according to severity and themes, trends and learning from the investigation of incidents was summarised for staff to review learning from incidents in other parts of the service as well as their own. For example, in September 2016 one major incident occurred in care group one and the investigation was in progress at the time of our inspection.
- Investigations of incidents were concluded with some form of learning event, for example a circular communication was prepared for staff which identified the learning. The chief executive's blog included examples of shared learning from incidents. Staff were able to give examples of learning from incidents which had been shared with them at team meetings. The organisation had identified the need to develop further its learning from the investigation of incidents, for example in providing feedback routinely to members of staff who submitted details of an incident.
- The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. A policy for duty of candour was in place and information about duty of candour was included in information governance training which was mandatory.
- If an incident involved patient harm the incident reporting system included a field which requested whether the duty of candour had been applied. Most staff understood the requirements of duty of candour and were open and honest in their interactions with patients. Duty of candour was taken into consideration during the investigation of incidents and we reviewed evidence of this.

Safeguarding

- Staff understood their responsibilities as to safeguarding. Patients at risk were identified at their assessment and a safeguarding indicator was used to identify the patient. Staff could review vulnerable adult or child safeguarding information in the patient's electronic record where information sharing was active.
- Urgent care staff confirmed they contacted the child's health visitor or school nurse if they had safeguarding concerns and documented this in the patient record. Information about children with injuries who presented at urgent care services was shared daily with the safeguarding children's team.
- Staff confirmed that there had been no recent safeguarding incidents which involved urgent care services. However, nurse practitioner staff we spoke with confirmed that they had previously used the safeguarding service to refer patients, particularly following home visits.
- Staff in urgent care services received safeguarding training during their induction. The service provided level two and level three training for staff. For care group one, 93% of staff had received safeguarding adults training. Staff we spoke with confirmed they had received safeguarding training at the level appropriate to their role.
- We saw that notices about the availability of chaperones were displayed in urgent care services, including within each consulting room. Staff in a focus group confirmed that chaperones were offered to patients. Non clinical staff were trained as chaperones, including reception and support staff who worked in the out of hour's service. Staff we spoke with confirmed they were aware, and complied with, the chaperone guidance.
- At the time of our inspection the safeguarding lead for urgent care services was being replaced as the previous lead had left the service.

Medicines

Good

Are services safe?

- Medicines were stored safely and securely, with access restricted to appropriately qualified practitioners. We checked medicines storage arrangements at the urgent care services we visited and observed the administration of medicines to patients. Medicine storage was in balance with records of medicine stocks and storage cupboards were locked. Temperatures for medicine storage were recorded daily and monitored to ensure they were within an acceptable range. Oxygen cylinders were stored safely and were within their expiry date.
- Staff in a focus group explained that they used a local joint formulary for primary and secondary care in Hull and East Riding. The joint formulary provided recommendations for drug treatments, and other approved treatments that may be prescribed by a specialist or on advice of a specialist. The formulary also provided information on the traffic light classification of drugs and linked to national and local guidelines. The joint formulary was updated every two months.
- Patient Group Directions (PGDs) are written instructions that allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. Patient group directions were followed to enable non-prescribing staff to give certain medications. We reviewed the PGDs in use and found they were up to date, reflected current best practice and were signed by staff who used them. Some urgent care practitioners were also qualified as independent prescribers and could prescribe from an approved list of medicines.
- Staff shared with us examples of reported incidents involving medicines and described the learning from the investigation of incidents. Urgent care services undertook a local audit of medicines every six months. We reviewed the latest audit report for 2016 which included recommendations and actions for the service.

Environment and equipment

- At the time of our inspection the Bransholme health centre was being reorganised to provide for the arrival of staff and equipment from minor injury units and out of hours services located at The Freedom Centre and Bilton Grange. Facilities for staff use at Bransholme included a training room. The consultation rooms did not have an engaged sign to show when the room was occupied.
- At the time of inspection no x-ray services were provided on site, but we were informed that from January 2017 x-ray services were to be provided at Bransholme in collaboration with an external NHS organisation.
- Automatic external defibrillators (AED's) were provided in each urgent care centre, available both at reception and within a sealed response bag. Oxygen and analgesic gases were provided in the consulting rooms. Larger chairs were provided for bariatric patients. We saw that recent checks of the equipment were completed.
- We observed that equipment was clean and well maintained. Maintenance stickers were attached to equipment, which showed the date the next service was due. Maintenance of specialist equipment was provided by an external NHS organisation. Service records were available. Staff escalated any items of faulty equipment to their line manager.
- To support home visits by the urgent care service, five response cars were based at the Westbourne health centre which each carried selected equipment including an AED, a medicines response bag and oxygen. The equipment was in date and a weekly check was undertaken.
- We observed three home visits and found that appropriate equipment to assess and treat the patient was available. Staff confirmed that an appropriate level and standard of equipment was also available in the urgent care centres.

Quality of records

- Patient records were stored in an electronic system widely used within the NHS in both acute and primary care settings. The system was implemented in April 2016 and replaced the electronic system previously used. Staff told us the current system was easy to use and they were complimentary about its ability to link electronically with most GP practices.
- We reviewed 20 patient records in current use within urgent care services. Patient consultations were thoroughly documented. Each record included the patient's previous medical history and details of their examination, diagnosis, treatment, current medication and any allergies. Risk assessments were completed appropriately.
- We observed that records were completed promptly either during the patient consultation or immediately afterwards by staff using laptops linked to the patient care summary record on the organisation's system.

Records could also mainly be shared with the patient's GP practice. In one instance we observed the patient record could not be shared with primary care because the practice did not use a compatible electronic system.

- Audits of records were completed in accordance with quality benchmarking standards used in the service and were undertaken by clinical team leaders. Feedback was provided for staff on the results of audit and a high standard of compliance was achieved.
- Access to records requested under the Data Protection Act was reported monthly as part of the quality and integrated governance report.

Cleanliness, infection control and hygiene

- The premises we visited were visibly clean and cleaning schedules were followed. Premises used by urgent care services were cleaned by an external organisation. We observed cleaning records were completed for cleaning activities undertaken. A cleaning monitoring report was prepared monthly for each urgent care services site and showed that a high level of compliance (usually in excess of 95%) was maintained.
- We observed that staff followed hand hygiene guidelines before and after patient consultations and alcohol based hand gel was available. During home visits we observed that staff followed hygiene procedures to maintain sterile methods of working and used alcohol gel between procedures. Staff used personal protective equipment (gloves and aprons) and disposed of used equipment appropriately. Staff followed bare below the elbows guidance. Clinical waste was disposed of appropriately.
- Clinical staff were responsible for cleaning reusable equipment and consulting rooms after use and we observed that this was followed. Cleaning schedules were followed for toys in clinical areas used by children.
- Urgent care services had a lead nurse for infection control who completed infection prevention and control audits. Hand hygiene audits were completed for all members of staff. Infection prevention and control incidents were reported monthly as part of the quality and integrated governance procedures.

Mandatory training

- A programme of mandatory and statutory training was available which staff undertook initially during their induction (usually four days) and subsequently by attending updates to training as these fell due.
- The organisation's internal standard for staff compliance with mandatory training was 80% and this level was exceeded for staff in urgent care services. Staff we spoke with confirmed their mandatory training was up to date, or was arranged. If staff attended training in their own time they were paid for their time.
- Staff were given notice by their line manager and the training department when they were due to attend training. Staff in a focus group confirmed that a training compliance matrix was reviewed every three months and the training department followed up with staff who were at risk of breaching their training timescales three months ahead.
- Compliance with mandatory and statutory training was reported monthly in the quality and integrated governance report. The report for September 2016 showed an overall level of compliance with training for the care group of 90%. Several subject areas achieved 99% compliance. The least well performing area was moving and handling for clinical staff for training repeated every two years which showed that only 61% of staff had completed this training. This was being addressed with a change in the training provider.

Assessing and responding to patient risk

- Urgent care services had developed a telephone triage interface to assess incoming calls. During the telephone triage call patients were prioritised based on their clinical need. We observed that clear information was given during telephone triage as to what action to take depending on the patient's condition. If the patient deteriorated, the patient was reprioritised and seen more quickly.
- Telephone triage staff were supported by a clinical decision support system widely used in NHS settings. Staff who used the clinical decision making tool spoke positively about the confirmation of their clinical judgement which the system provided. Patients presenting with high risks and deteriorating patients were identified and similar conditions were assessed consistently.
- Support staff at the reception for walk-in patients received basic life support training. We were informed that if an unwell patient presented at the reception, support staff were experienced in providing an initial visual assessment and contacted help as needed. A "Support staff prioritisation protocol" was used for patients presenting at reception and we observed that

support staff used this appropriately. For example, if a patient was in a collapsed state an ambulance was called. Support staff told us that in these circumstances they would ring internally for an available clinician and would get an almost immediate response.

- We observed that the NHS Early Warning Score (NEWS) was available for use and information about this was displayed in patient consulting rooms. Clinical staff told us that although they were aware of NEWS, they were unlikely to use the tool in practice as the patient was usually not in the department for long enough for this to be appropriate.

Staffing levels and caseload

- For the six months prior to our inspection, the introduction of an integrated urgent care service meant the vacancy rate had reached 8%. However, within urgent care services there was just one vacancy at the time of inspection.
- We were informed that although no formal staffing model was in place, the approach used for staff planning was based on service demand and the skills of available staff. E-rostering was used for staff planning. Staff we spoke with confirmed they felt there were enough staff available in urgent care services.
- Staff in a focus group told us that some experienced staff had left the organisation due to recent changes in urgent care. For example urgent care practitioners who previously undertook home visits during the day, were now expected to work some unsocial hours. This had involved significant changes to staffing rotas in the previous six months. Urgent care staff did not operate from a particular base and were expected to work at different sites according to need. This had placed additional demands on existing staff but a new cohort of staff had been recruited. Some staff were employed on a flexible working contract.
- Staff shift patterns at the Bransholme health centre were arranged in a staggered pattern. On the "early" shift staff worked from 9am to 5pm; on the "late" shift staff worked from 12noon until 8pm and on the "long" shift from 9pm to 8am. Shifts were staggered to minimise the effect of handovers and to maintain patient flow. Nursing handovers were not used in the usual way due to the continuous staggered shifts.
- At Westbourne health centre staff were deployed on an 11 week rolling rota which included day and night shifts. For example, urgent care practitioner staff may be expected to work from 6.30pm to 7.30am the following day.
- For medical staff, a separate GP rota was used which included the use of locum agency staff for the out of hour's service. Managers informed us that there were difficulties in recruiting GP's to the area and more bank and agency staff were used particularly during recognised peak times, which was planned for. Nurse practitioners were also deployed to fill gaps in medical staffing. On a few occasions, commissioners had been approached for permission to close a centre early due to GP shortages and to consolidate the service at another centre. Business continuity arrangements were in place and this situation was also being addressed by the consolidation of urgent care services at the Bransholme health centre.

Managing anticipated risks

- Urgent care services maintained a resilience and business continuity plan to enable the service to respond appropriately to adverse events affecting service delivery. Examples of these events included inclement weather and unexpected peaks in demand for services.
- A lone working policy was in place when working alone. Mobile phones carried by staff included a lone working application intended to be activated during a home visit. Lone worker applications were not used consistently as all staff were chaperoned in the out of hours service.

Major incident awareness and training

- Business continuity arrangements were in place with acute services for responses to major incidents. The care group director for emergency care and the senior operational manager for urgent care were jointly the accountable officers for emergency planning. Urgent care services were represented on the local resilience forum, which met monthly.
- We observed a major incident scenario which the service participated in as part of its contribution to the local resilience forum. The service was one of a range of organisations involved including the police, fire and rescue and ambulance services. We saw that resilience planning was applied as part of the major incident plan

Good

Are services safe?

for the city of Hull. Actions were rehearsed which included the mobilisation of medical staff and equipment for an appropriate emergency response. Recovery arrangements included an appropriate assessment of risk.

- Major incident awareness training was completed as part of staff induction.

Good

Are services effective?

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

Summary

We rated effective as Good because:

- The service followed evidence based guidance to ensure the effectiveness of treatment.
- Staff competence was supported through regular supervision and appraisal and staff received training and support to develop their clinical skills.
- Multi-disciplinary working and coordination of care pathways was well developed. Urgent care liaised effectively with other health services.
- Pain symptoms were assessed quickly and patients were offered medication for pain relief.
- Staff had ready access to patient information and guidance using mobile IT equipment.
- Staff followed consent procedures and were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- The service planned to provide integrated urgent care seven days a week, twenty four hours a day.
- Quality monitoring included audits of urgent care which prioritised service quality.

Detailed findings

Evidence based care and treatment

- Urgent care services used National Institute for Health and Care Excellence (NICE) and supporting clinical guidelines and patient group directions to ensure the effectiveness of treatment provided for patients.
- The organisation's NICE guidance review group considered guidance published by NICE each month to assess how it applied to services. Newly published NICE guidance was then circulated to NICE leads within services. The number of items reviewed or outstanding was reported and summarised in the monthly quality and integrated governance report. Staff in a focus group confirmed their use of the latest NICE guidance supported by the work of the review group.
- The organisation was registered as a NICE stakeholder for key service areas including urgent care so that it could be consulted about guidelines and quality standards being developed which impacted on clinical services. Work with NICE guidance was undertaken in conjunction with commissioners.
- The clinical audit programme reviewed requirements to meet external standards which included National Institute of Care Excellence (NICE) guidance published during the year.
- When we observed care and treatment being given to patients we found that the diagnosis and subsequent treatment of the patient was based on evidence and best practice. NICE guidance was followed by nurse practitioners. The NICE traffic light system for identifying risk of serious illness was displayed in consulting rooms.
- The clinical decision support system used in the telephone triage of patients was based on NICE guidelines. For patients with sepsis, we found that nurse practitioners used appropriate national guidance and tools to support an early response to the patient's condition. National guidance was followed in the management of patients with cellulitis.
- The Royal College of General Practitioners clinical toolkits were used in urgent and out of hours care to support the delivery of effective care for patients. The clinical adviser for urgent care had reviewed the relevance of the toolkit to the organisation's services.

Pain relief

- At the locations we visited, patients we spoke with confirmed their pain had been assessed and they had been offered medication for pain relief.
- We observed nurse practitioners as they undertook the initial assessment of both adult and paediatric patients. Staff asked the patient whether they were experiencing pain and whether they required pain relief. Staff also explained to the patient about the appropriateness of pain relief and the likely effect of taking medication and the expected effect in relieving their pain symptoms.
- The patient's pain symptoms were scored. The patient records confirmed that pain scoring were undertaken and medicine was offered and administered as appropriate to alleviate the patient's pain symptoms.

Good

Are services effective?

- Staff in a focus group confirmed that medication for pain relief was offered to patients and a range of pain relieving medicine were available for this purpose, including intravenous analgesics for use in an emergency.

Nutrition and hydration

- Patient visits to urgent care services were usually not of long enough duration for food and drinks to be needed during their stay. We observed that water dispensers were provided in the reception and waiting areas of the locations we visited so that patients and their carers could help themselves to water.
- We found that food preparation and food storage facilities were available so that patients could be offered food and drink if necessary. The locations we visited also included some facilities for patients to purchase drinks and snacks.
- When we observed urgent care practitioners during home visits, we found that in appropriate instances the patient's assessment included questions about their diet and the preparation of their meals and about their fluid intake.

Patient outcomes

- The essence of care standards relevant to local community services were reviewed within the quality monitoring programme (QMP). During 2015-16 358 QMP audits were carried out across 45 clinical services including urgent care. The audits were analysed and action plans prepared for each service. For example, during 2015-16 the audit monitored the effectiveness of care for people at risk of falls.
- We were informed that one of the twelve essences of care benchmarks was reviewed each month to compare clinical practice. Action plans were prepared which identified areas to improve practice. The clinical adviser for urgent care undertook a clinical audit every six months in agreement with commissioners. An action plan was prepared for audit scores of less than 80% and the area of practice was re-audited within six months.
- We were informed that the secondary referral admission rate for patients who attended urgent care services was 6 to 7%.

Competent staff

- Staff new to the organisation received a comprehensive induction typically of four days duration so that they understood the organisation and how it worked. Staff in a focus group told us the service had developed a "clinical passport." Supervised by senior staff, a competency book and observed assessments were completed prior to the clinician working unsupervised. A preceptorship programme was available for new members of staff.
- Staff were supported to develop their clinical skills. Several members of staff gave examples of how their development was being supported. Urgent care services had developed the nurse practitioner role. As different members of staff had achieved different levels of competency the development pathway available to each member of staff reflected their existing skill base and specialisms. An associate practitioner role had been developed and the service employed apprentices to develop and give opportunities to local people.
- Urgent care practitioners (Band 5 and 6) were supported in developmental roles. Nurse practitioners who presently worked in minor injuries were supported to extend their skills to include minor illness and to undertake further training, for example in autonomous practice skills.
- A cohort of four new members of staff were being supported with their university courses. Each developmental member of staff was assigned to a mentor. Staff told us they valued the support they received through preceptorship, mentoring and work shadowing and said they appreciated the training they received.
- Urgent care services had introduced a paediatric nurse practitioner role. One of two paediatric nurse practitioners was in a developmental role. Other nurse practitioner staff had different levels of paediatric experience. We observed that staff supported each other and could call on a colleague for advice or to refer a patient for a second opinion from a more senior member of staff or specialist. A telephone triage role for nurse practitioners was also supported.
- Each member of staff received regular supervision. The clinical adviser for urgent care undertook clinical supervision; for example clinical team leaders received a clinical assessment of their practice. Clinical team leaders had fully completed their training and three of four staff were nurse prescribers.

Good

Are services effective?

- Information we received showed that 88% of staff had received an appraisal in the previous 12 months. Staff we spoke with had received their appraisal and spoke positively about it.
- Professional revalidation of nursing and medical staff was supported. A policy to support professional revalidation for staff was in place.

Multi-disciplinary working and coordinated care pathways

- The senior operational manager met with senior staff from the local acute trust to liaise and coordinate care pathways and the planning of urgent care services. Acute services were involved in the development of x-ray facilities at the Bransholme centre and in the provision of care pathways for x-ray referral of patients out of hours.
- The service worked with the local acute trust in referring patients for treatment following assessment, where this was appropriate, including for example physiotherapy and mental health services. The service was able to refer patients to the local acute hospital services using agreed pathways and urgent care practitioners had admitting rights for certain agreed services.
- We observed the assessment and reviewed the records of two patients who were referred. The nurse practitioner spoke with acute services by phone to liaise about arrangements for the patient's arrival.
- Urgent care services participated in a recently established falls response pilot scheme with the ambulance service, fire and rescue and other health services. Hull FIRST (Falls Intervention Response Safety Team) involved input from nine public services and the six month pilot was supported by commissioners. Emergency care practitioners (ECPs) based in urgent care provided the clinical input and had trained ten fire officers involved in Hull FIRST. Where a clinical assessment or medical treatment was needed following a fall, ECPs worked with other clinicians at the patient's home or at the scene of the fall incident to help avoid unnecessary transfer to hospital.
- Urgent care services was a member of the local resilience forum. We observed a major incident scenario in which the service was one of a range of organisations involved including the police, fire and rescue and ambulance services. Actions were rehearsed which included the mobilisation of medical staff and equipment for an appropriate emergency response.

Referral, transfer, discharge and transition

- We found that urgent care services liaised effectively with other health services within CHCP CIC about the care and treatment of patients, including community services for adults, children's services and end of life care services. When patients were referred to their GP following their consultation, staff checked that patients were happy with this outcome. When patients were referred to the acute hospital staff explained about transport and how to access the service they were visiting when they arrived.
- We observed two home visits in which the urgent care practitioner liaised with the district nursing service to ensure the patient's care was supported appropriately. We saw that the practitioner wrote in the patient's care plan, so the domiciliary care team would understand the treatment.
- When patients were discharged, discharge letters were sent electronically, supported by a phone call for more serious or urgent cases.

Seven-day services

- At the time of our inspection urgent care services were being relocated from Bilton Grange health Centre and the Freedom Centre to Bransholme Health Centre as part of the realignment of services agreed with commissioners. The service planned to provide urgent care services based at Bransholme seven days a week, twenty four hours a day.
- We visited the Bilton Grange health centre out of hour's service which was closed in November 2016 following the inspection. We found that current arrangements for access to out of hour's urgent care and treatment based at the existing locations were to be extended further following the move to Bransholme.
- The current out of hour's service was operated by emergency care practitioners (ECPs) and GPs. ECPs undertook home visits where appropriate. We were informed that managers and senior staff could be contacted for advice at the weekend so that staff felt supported out of hours.
- The radiology service was to be provided at the Bransholme Health Centre from January 2017 and it was planned to operate the service from 8am until 8pm, seven days a week.

Access to information

Good

Are services effective?

- Staff accessed policies, procedures and guidance through the organisational intranet. Each member of staff had their own email account. Staff spoke positively about the chief executive's blog which they received weekly. We were informed that a newsletter for urgent care services was in development.
- Staff used mobile IT equipment to access patient records so that information could be accessed and records completed in the patient's own home, subject to IT connectivity being available at the remote location.
- In the centres we visited we observed that information was displayed about the staff on duty and their roles, the opening times of the service, and the waiting time to be seen. A quarterly newsletter was available for members of the public.
- Practitioners accessed and shared electronic patient records within the organisation and with appropriate consent and where systems were compatible, with the patient's GP and other healthcare professionals. However, we found that although almost 90% of GP practices used a compatible system, most practices did not allow the sharing of patient information. Arrangements to resolve this issue through commissioners were in progress at the time of our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Urgent care services staff we observed demonstrated an appropriate understanding of legislation and guidance related to consent and the Mental Capacity Act (MCA). Staff were also aware of guidance related to the application of Gillick competencies for paediatric patients. Staff were briefed and aware of Deprivation of Liberty Safeguards (DOLs).
- Staff received training in MCA and DOLs as part of their induction and three yearly thereafter.
- Patients were involved in decisions about their care and treatment where appropriate. When we observed care being given we found informed consent was obtained at each stage of care and before observations and treatment and to access care records held by the patient's GP. DOLs was identified particularly when a patient received a home visit.
- The patient records we reviewed showed consent was appropriately documented and included consent to share information. We reviewed an example of a patient record where the application of MCA was documented. Tools to assess capacity where available and we were informed that the system was being developed to include a specific framework for MCA, including a template for assessment of mental capacity.

Good

Are services caring?

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

Summary

We rated caring as Good because:

- Patients received friendly, compassionate care and treatment which was well directed to their needs. Staff had an excellent rapport with paediatric patients and were particularly courteous and understanding with older patients.
- Staff explained what they were doing to patients so that they understood well the details of their diagnosis and treatment.
- Patients were encouraged to be involved in their care and treatment plans were explained to the patient so that self-care was promoted.
- Staff helped patients and their relatives and carers to cope emotionally with their care and treatment.
- Patients' privacy was respected and confidentiality was maintained.

Detailed findings

Compassionate care

- Patients and their relatives and carers at each urgent care location we visited spoke positively about the care and treatment they received. Patients spoke about the convenience of the service and the relevance of the diagnosis they received. Patients felt supported and said the staff they met really cared about them. Patients told us they were happy with the service they received and said staff were friendly to them. We observed that staff had an excellent rapport with paediatric patients and set them at ease. With older patients, staff were particularly courteous and understanding.
- We observed as staff delivered care and treatment to both adult and paediatric patients in the urgent care services locations we visited, in people's own homes, and in a residential care setting. We observed interaction between staff and patients and saw that people were treated consistently with dignity, respect and kindness. Staff were sensitive to patient's needs; they anticipated patient's needs and responded promptly and compassionately when people needed help.
- Staff in a focus group explained that to support friendliness, each practitioner introduced themselves to the patient by name. Our observation of care and treatment and of staff receiving incoming telephone calls from patients confirmed this.
- Patients' privacy was respected and confidentiality was maintained. At a previous inspection concerns were raised about a lack of confidentiality at the reception. The service had addressed these concerns and told us that privacy was seen as paramount. A notice about privacy was displayed at the reception and patients were given the option of speaking in a private area if they preferred. A second notice asked the patient to inform reception if they preferred to be seen by a person of the same gender. When the reception desk was busy patients were allocated a number and were called forward individually to give information.

Understanding and involvement of patients and those close to them

- Patients and their relatives and carers at each urgent care location we visited told us they appreciated their assessment, care and treatment. They told us staff explained things to them really well so that they understood the relevance of the diagnosis and treatment they received.
- Patients were encouraged to be involved in their care and in making decisions about their care with the support they needed. Staff spent time listening to patients and their relatives and carers and in responding to them. Staff communicated with people in a very understandable way so that patients understood the assessment of their condition and the care and treatment that staff had identified was needed. Treatment plans were explained to the patient and self-care was promoted.
- We observed that staff had an excellent rapport with paediatric patients which they used to full advantage in explaining what was happening in simple terms to the child. For older patients with some cognitive impairment, staff patiently explained and repeated what the patient needed to know about each stage of their assessment, care and treatment. We listened in when

Good

Are services caring?

staff spoke with patients on the telephone and gave advice about after care, for example the removal of a dressing or medication. Explanations were given clearly and staff answered any questions the patient had.

Emotional support

- Staff helped patients and their relatives and carers to cope emotionally with their care and treatment. We observed staff as they provided emotional support to patients and their relatives and carers in the health centres and during home visits. For older patients with some cognitive impairment, staff provided reassurance. The time was taken to ensure emotional support was shown by enquiring about the involvement of family and friends. With paediatric patients, staff were very empathic and skilfully provided emotional support as they gained the child's confidence.
- If a patient arrived in emotional distress, a separate room was identified and they were offered emotional support and time alone if they preferred. A patient who received emotional support told us that staff were really nice and listened to them. Staff in a focus group explained that when they provided emotional support they focussed on listening skills and on picking up the 'unsaid things'. Staff could refer patients to mental health services if more specialised support was required. Further training for staff in mental health was planned.
- Patients were enabled to manage their own health. Their care and treatment was explained in a way which enabled patients to want to do this. With older patients, staff ensured they were not isolated and were able to continue looking after themselves.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as Good because:

- Urgent care services were planned and delivered to meet patients' needs. An integrated urgent care service was being introduced in response to people's needs which followed commissioner's requirements for the service.
- Access standards were consistently achieved. Key performance indicators showed that 100% of patients who attended the service's minor injuries units were seen within four hours of arrival. Patients told us they were seen in a shorter time than they expected.
- Equality and diversity considerations were reflected in planning and delivering services. Equality and diversity training was part of mandatory training. It was easy for staff to access telephone interpreters.
- Facilities were designed for disabled access and wheelchairs were available at the front of buildings.
- Patients with a learning disability were supported. Carers were involved in the planning of care and treatment where possible and a specialist learning disability team was also available to provide support.
- Patients with mental health needs were referred to specialist mental health services during their triage or at their assessment.
- For bariatric patients, a home visiting service was available for patients who were unable to travel to the service.
- Although the service did not receive many complaints, the service learned from those it did investigate, and learning was shared.

Detailed findings

Planning and delivering services which meet people's needs

- Urgent care services in care group one brought together services which were previously operated in separate business units and which included minor injuries, GP out of hour's services and the home visiting service as part of the organisation's integrated plan for 2010-15.
- At the time of our inspection the service was in the process of further integration of community services in response to commissioner's requirements. Services based at Bransholme health centre were being extended to provide integrated urgent care seven days a week, 24 hours a day from April 2017. Most staff we spoke with felt urgent care services operated more effectively as an integrated service and supported the planned changes.
- Urgent care services would continue to be provided from the Bridlington hospital site. The facilities at the Westbourne health centre were being developed to support paediatric patients. At the Freedom Centre the service planned to provide signposting and support for minor injuries from April 2017 so that local people received continuity of support for their needs.

Equality and diversity

- The organisation's stated corporate values included equality and diversity. The organisation's equality and diversity annual report for 2015 – 2016 included an equality strategy action plan for 2016-19 which included urgent care services. We reviewed the minutes of an equality and diversity meeting held in 2016 which provided evidence of actions taken in relation to equality and diversity.
- Urgent care services reflected the diverse needs of the local community it served. Staff could access interpreter services, including a face to face translation service. We observed in the reception areas of the centres we visited that patients were invited to request an interpreter if they required. Staff told us it was easy to access telephone interpreters.
- Staff who could communicate in Makaton (a language programme using signs and symbols to help people communicate) were available to help patients with these communication needs.
- The urgent care facilities we visited provided access for people with disabilities. We were informed that the buildings had been designed to provide disabled access. Wheelchairs were available at the front of buildings.
- Equality and diversity training was part of mandatory training and most staff in care group one had completed this training.

Meeting the needs of people in vulnerable circumstances

Good

Are services responsive to people's needs?

- For bariatric patients, larger chairs were provided at the Bransholme health centre. A home visiting service was available for patients who were unable to travel to the service.
- For patients with a learning disability, the person's needs were identified in their patient record and their carer was involved in the planning of care and treatment where possible, for example where the patient lived in a residential home, to ensure an appropriate care plan was prepared for the patient. A specialist learning disability team was also available to provide support.
- Patients with mental health needs were referred to specialist mental health services during their triage or at their assessment. Patients could be signposted to the Let's Talk service which provided an initial level of support and signposting to crisis resolution or other specialist mental health services.
- Urgent care services did not provide chaplaincy or other pastoral care services.

Access to the right care at the right time

- The organisations Key Performance Indicators for 2015 -16 showed that 100% of patients who attended the service's minor injuries units were seen within four hours of arrival.
- The service performance report prepared for commissioners included exception reports for each care group which confirmed that access standards were achieved consistently.
- In the reception areas of the urgent care centres we visited we observed that information was displayed about the waiting time to be seen. We observed that the waiting time shown was usually 30 minutes and in a few instances 60 minutes. Patients were seen within these times. During our observations the longest time a patient was in the centre was 41 minutes.
- We observed patients who arrived at reception asked about waiting times to be seen and staff replied informatively. Patients who contacted urgent care services by telephone could arrange a time to visit the service which was convenient for them. Patients told us they were seen in a shorter time than they expected.
- Staff told us they were experienced in handling peaks and variations in the arrival of patients in the centre and they aimed to see patients as soon as possible. Patients were normally seen according to the time they arrived but when the centre became busy patients were seen according to the priority of their needs. The service operated a protocol to ensure all patients that arrived were seen by the service and we observed that this was followed.
- Prior to our inspection we received information that indicated patients had experienced undue delay before being seen at the service's minor injuries units. Our observation of the arrival of patients did not confirm this. We observed the arrival of patients at four minor injuries service locations. We observed that patients were seen very quickly and most were seen within two hours of arrival.
- Prior to our inspection we received information that indicated the out of hours GP service had been closed before advertised times. We were informed that the occasions when the service closed early were quite infrequent, and in these instances alternative arrangements were made for patients to attend another location and the permission of commissioners was obtained before closing the service.

Learning from complaints and concerns

- For urgent care services, eight complaints were received, three of which related to Bransholme health centre, four related to Bridlington Hospital and one related to the Freedom Centre.
- The monthly quality and integrated governance report included information about comments, compliments, complaints and concerns received by the service. Complaints were reported through the care group safety and quality forum. This information showed that in September 2016, one formal complaint was received which related to urgent care. Staff in a focus group confirmed that the service did not receive many complaints.
- The service used a complaints guide, a complaint evaluation document and a complaints feedback form for staff to use.
- A complaints leaflet and a patient opinion card were available for patients to use.
- The service used the recorded information about comments, concerns, complaints and compliments received during 2015-16 in its published quality accounts which showed a service user satisfaction rate of 98%.

Good

Are services responsive to people's needs?

- The clinical adviser for the service involved in the investigation of complaints explained the outcomes of a recent investigation. A learning document was prepared for staff after the investigation was completed and staff development needs were identified.

Good

Are services well-led?

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

Summary

We rated well-led as Good because:

- The organisation's vision and strategy was embedded and urgent care staff identified with the organisation's mission, values and corporate objectives.
- Arrangements for the governance, risk management and quality measurement of urgent care services were in place. Items identified for action were followed up.
- Staff said the chief executive provided clear, visible leadership of the organisation. Directors of the care group which included urgent care and senior managers of the service provided clear and reliable operational leadership.
- Staff felt valued and supported by managers and were proud to work for the service.
- The culture of the organisation and of urgent care services was positive and patient focussed.
- Public engagement was well developed and the service achieved high levels of patient satisfaction which compared well with similar services nationally.
- A staff engagement strategy was in place and staff were consulted. Staff survey results showed staff satisfaction had improved year on year and the organisation compared well with similar services nationally.
- Quality and sustainability considerations were reflected in the redesign of services and the service could demonstrate examples of improvement and innovation. Staff involved were recognised through an internal staff award scheme and by nomination for external awards.

Detailed findings

Leadership of this service

- Staff we spoke with said the chief executive was approachable and communicated well with staff at all levels. Staff told us the executive team were well informed and supportive. Staff said they felt comfortable speaking with members of the executive.
- The director for the care group and the senior operational manager for urgent care provided operational leadership for urgent care services. They were supported by four clinical team leaders who reported to the senior operational manager.
- Most staff we spoke with felt they were well supported by service managers. Staff spoke positively about the accessible and supportive local leadership they received. Staff of all grades told us that managers listened to their concerns. Senior managers were open and honest. The team was seen as well oriented by all grades of staff.
- The clinical adviser for urgent care undertook clinical assessment of the clinical team leaders. The clinical adviser for urgent care reported to the medical director.

Service vision and strategy

- The organisation's vision and strategy was embedded. The organisation's values were service and excellence, equality and diversity, creativity and innovation and co-operation and partnership. The corporate objectives reflected the organisation's corporate mission and values and included five overarching strategic goals with indicative dates. The organisation's business plan for 2016-17 contained four quality and integrated governance team corporate objective plans and actions, measures and deadlines which included urgent care services.
- We found staff identified with the organisation's mission, values and corporate objectives and felt it was reflected in the plans for the strategic development of urgent care services. Staff in a focus group said the organisation's vision, corporate objectives, and service and team objectives had been known for each of the services for two to three years. Staff knew where to find information about the organisation's mission and strategic direction and they said managers kept there aware of changes.
- The organisation's Commissioning for Quality and Innovation (CQuIN) indicators were agreed with

commissioners. The lead responsibility for each strategic goal was allocated to a senior member of staff, indicative dates were identified and updates were compared with the planned achievement dates.

Governance, risk management and quality measurement

- There was a governance framework for each part of the organisation, including care group one which covered urgent care services and exceptions were reported to the Board.
- The corporate risk register included current risks identified for each business unit and risks identified for integrated urgent care were included in care group one. The register provided a risk rating, a summary action plan, a nominated handler, and review timescales. The risks identified for urgent care included risk to meeting service specifications from changes to working practice following the alignment of three different service areas, including skills and competencies of staff groups, some fragmentation in record keeping, and patient pathways.
- The patient safety and governance meeting was held every second month and provided an oversight of clinical governance for the organisation and included urgent care services. The governance lead and the senior operational manager for urgent care attended this meeting.
- A quality and integrated governance monitoring report was prepared monthly for the care group which provided an operational overview. The report included an update on risks, serious incidents, complaints, quality monitoring, training and other key indicators which were reviewed by the governance lead for the care group.
- Urgent care services held a six weekly team meeting which was attended by senior staff. The team meeting was chaired by the senior operational manager. An operational agenda was reviewed to identify issues and actions to escalate to the safety and quality forum. The meeting was minuted and staff who attended the meeting confirmed that actions identified were followed up.

Culture within this service

- Staff spoke positively about the culture of the organisation and of urgent care services. Staff said their colleagues were patient focussed, professional and pleasant to work with. Staff felt there was an open, friendly and very positive culture.
- Staff said they were told at induction that the culture was staff oriented, patient oriented and informed. They said even though it was a busy environment to work in it seemed very relaxed. They felt valued and were well supported. Staff told us they were expected to work hard and represent the organisation and they felt that was what they did. They were proud to work for the service and were proud of the job they did.
- Almost all staff were positive about the way the changes being introduced to the service in the previous 12 months and at the time of our inspection were handled. Most staff felt morale had improved as a result of the changes and were positive about them. They appreciated that staff were supportive of one another.

Public engagement

- The friends and family test could be completed using cards, tablets, phones or online. The organisation's quality accounts for 2015/16 included the overall results of the friends and family test (FFT) between April 2015 and March 2016. FFT showed that 12,252 people responded and 96.2% said they would be likely or extremely likely to recommend the service; 98% were satisfied with the overall experience; 98% satisfied were with the standard of care and support; 92% were likely to recommend; and, 96% got the care that mattered to them.
- In conjunction with commissioners, the reorganisation of urgent care services was the subject of extensive public consultation which included postal surveys and patient participation groups. Focus groups for carers and people with dementia were held in conjunction with the carer's information and support service.
- At the Bransholme health centre examples of changes included extended hours and weekend opening and provision of x-ray facilities on site. The organisation adopted the options favoured by the public. A newsletter for the public was published quarterly which included updates about changes to services.
- Activities and information for the public was coordinated through the organisation's engagement team. For example, the service held patient groups for some services in conjunction with GPs. Members of the

public could contact the service through social media to provide feedback or request information about services. Voting boxes were available at some locations for patients to select the quality of service they had experienced and the results were displayed on the organisation's website. Patients were also signposted to an independent patient opinion website to tell their story. The use of information technology for public engagement was being extended with the support of commissioners.

- The annual patient survey snapshot previously undertaken had recently been changed to a weekly survey of patients who attended urgent care services in the patient perceived outcomes survey which was reported quarterly. The audit of patient satisfaction required at least 1% of patients to respond to meet national requirements; the service aimed to obtain responses from 5% of patients. Staff told us that the feedback they received from patients was really positive and this was confirmed in our conversation with patients.
- The service used the strapline "You talk, we listen" for its public engagement and we observed these posters in public areas we visited. The organisation's quality accounts for 2015/16 included an account of how the service responded to suggestions from patient experience activities undertaken. Examples included work undertaken to improve services in response to people with a disability, and improved signage to services. Other examples in which the service had responded to the suggestions of patients included the provision of TV in waiting areas, toys for children and baby changing facilities.

Staff engagement

- Staff had been well informed about the reconfiguration of urgent care services and some staff were nominated change champions. Most staff spoke positively about being consulted as to the changes and their involvement in the development of urgent care services.
- An annual staff survey was carried out. The staff survey for 2015/16 had 852 responses which represented 63% of staff. The results of the survey showed that 85% of staff agreed that the care of patients was the organisation's top priority. Staff indicated that they would be likely to recommend the service to friends and family should they need care or treatment in 92% of instances; 94% of respondents felt that they were trusted to do their job; 92% agreed that colleagues treated them with respect; 89% said colleagues sought their opinion; 77% of respondents said their job satisfied them, and 79% of respondents would recommend the organisation to friends and family as a place to work, which was better than other comparable organisations.
- When compared with the 2014/15 survey, there had been a 4% increase in respondents who would be either extremely likely or likely to recommend the organisation to friends and family if they required treatment (from 88% in 2014 to 92% in 2015). Recommendations were also more than a fifth (24%) higher than community trusts nationally.
- The survey showed the level of engagement of staff: 82% of respondents were satisfied with the encouragement they received to suggest new ideas to improve services; 62% of respondents felt involved in the development of their business unit, and 62% felt involved in decisions which might affect them.
- Survey results identified where improvement was required and leads and timescales were assigned for action points. Whether improvements were completed or not achieved was recorded. Staff gave us examples of developments in the service as a result of consultation. Monthly staff meetings were started in response to the staff survey and these meetings were used to consult with staff, for example, to ask about preferred hours of working.
- We observed in the staff area a notice requesting staff feedback, information about how to make comments and suggestions, engagement events, the shareholder forum, the chief executive's forum and telephone surgery with times and contact numbers, the annual staff survey and information about the freedom to speak up guardian. The chief executive also provided a comments box for staff to post their views. Staff we spoke with were aware, and referred positively, to the chief executive's survey "snapshot". Feedback to staff was included in the weekly newsletter. Staff told us they felt communication with staff had improved further in recent months.

Innovation, improvement and sustainability

- The review and provision of integrated urgent care services in conjunction with commissioners took account of quality and sustainability considerations in the redesign of services. Financial considerations were not being used to compromise the quality of care. The

Good

Are services well-led?

quality of care and treatment provided was underpinned by the service's focus on the learning and development for staff, which was supported by commissioners.

- Staff gave several examples of the service's innovative approach to staff support, particularly the development of the advanced nurse practitioner role over the previous 12 months, with competencies extended to include both illness and injury.
- Urgent care services had developed a telephone triage interface to assess incoming calls. During the telephone triage call patients were prioritised based on their clinical need. If the patient deteriorated, the patient was reprioritised and seen more quickly. Telephone triage staff were supported by a clinical decision support system widely used in NHS settings. Patients presenting with high risks and deteriorating patients were identified and similar conditions were assessed consistently.
- Urgent care services participated in a recently established falls response pilot scheme with the ambulance service, fire and rescue and other health services. Hull FIRST (Falls Intervention Response Safety Team) involved input from nine public services and the six month pilot was supported by commissioners. Emergency care practitioners (ECPs) based in urgent care provided the clinical input and had trained ten fire officers involved in Hull FIRST. Where a clinical assessment or medical treatment was needed following a fall, ECPs worked with other clinicians at the patient's home or at the scene of the fall incident to help avoid unnecessary transfer to hospital.