Primary Care/Urgent Care Centre

Inspection report

Blackpool Victoria Hospital
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Blackpool
Lancashire
FY3 8NR
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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 summary

We carried out an announced focused inspection at the Primary care / Urgent Care Centre on 5 June 2019. This inspection was carried out in response to concerns identified during an inspection of the Urgent and Emergency Services at Blackpool Victoria Hospital on 7 January 2019. At this inspection, only those identified concerns were examined within the key questions of Safe and Well-led, therefore there are no ratings associated with this inspection.

At this inspection we found:

- There were good arrangements for the security of all staff and patients in the Urgent Care Centre.
- Staff working on the reception point desk used pathways and navigation tools to good effect to safely direct patients to the most appropriate service.
- There was improved support for reception point staff and ongoing review of patient pathways and outcomes.
- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes. Learning was shared with other services.
- The service worked collaboratively with other providers in the Urgent Care Centre to ensure governance systems were comprehensive and effective. There were regular joint clinical governance meetings.
- There was a focus on continuous learning and improvement at all levels within the service.

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Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC inspection manager, a second CQC inspector and a GP specialist adviser.

Background to Primary Care/Urgent Care Centre

Primary Care / Urgent Care Centre (Blackpool Victoria Hospital, Whinney Heys Road, Blackpool, Lancashire, FY3 8NR) is a registered location under the provider Bloomfield Medical Limited and delivers urgent care services to the Fylde Coast population. The service is part of the NHS Blackpool clinical commissioning group (CCG). The provider is registered to carry out the regulated activities of diagnostic and screening procedures as well as treatment of disease, disorder or injury at this location. Bloomfield Medical Limited are working in collaboration with other local urgent care providers to align the service provision at the Urgent Care Centre in Blackpool hospital with other local sites as part of the Fylde Coast Integrated Urgent Care Service (FCIUCS). The providers share managerial oversight of the urgent care provision across the system in order to better manage demand and resources to ensure patient needs are met.

The Urgent Care Centre is a purpose-built facility within the local NHS Foundation Trust hospital premises and shares its reception area with the hospital's accident and emergency department.

The centre provides open access primary care to local and temporary residents and visitors to the Fylde Coast either by appointment through the NHS 111 service, to patients walking into the centre or from the local North West Ambulance service. The service's reception is staffed by staff from FCMS (NW) Limited who are trained to liaise with patients on arrival and signpost them to the appropriate service. The Urgent Care Centre is open 24 hours a day, seven days a week, all year round. Bloomfield Medical Limited provide clinical staff every day from 8am to 10pm. FCMS (NW) Limited provide clinical staff in the period from 6.30pm to 8am Monday to Friday and all day on a Saturday, Sunday and bank holidays. There is an overlap of Bloomfield and FCMS clinicians between 6.30pm and 10pm Monday to Friday and they work alongside each other on a weekend and bank holidays. In addition, the provider also delivers a nurse-led deep vein thrombosis service from the centre, with pre-bookable appointments available between 9am and 5pm Monday to Friday.

The centre is staffed by a team of GPs, advanced nurse practitioners, non-medical prescribers, practice nurses and health care assistants. The clinical team are supported by an operational lead and team of other non-clinical personnel including an HR lead, receptionists and administration staff. The staff at the centre are also supported by a broader management structure within the provider organisation and those other providers in collaboration as part of the integrated urgent care system across the Fylde coast.

The provider ensures a GP is on site throughout the location's operational hours of 8am until 8pm each day.

Are services safe?

Safety systems and processes

During our inspection of the Urgent and Emergency Services (ED) at Blackpool Victoria Hospital on 7 January 2019, staff working for the security service provided by the Hospital Trust indicated they were told not to support the Fylde Coast Integrated Urgent Care Service (FCIUCS) staff as there was no financial contribution made for this service. They indicated however, that they did respond when the need arose.

At this most recent inspection we spoke with security staff and reviewed safety arrangements with FCIUCS. We found the service had systems to keep people safe.

- Security staff we spoke with confirmed they would provide support when needed and reception point staff confirmed this. We also saw emails from the Trust Security Advisor and the Safety Team manager that confirmed all support was available to the Urgent Care team.
- Managers at FCIUCS gave us evidence of payments to the Hospital Trust for security services.
- Because there had been a recurring situation related to staff security during the night, FCMS had employed additional private security staff to protect the Urgent Care service from midnight to 7am. Staff we spoke with told us they felt more comfortable at work since this extra provision.

The inspection of the ED in January 2019 raised concerns about children waiting in the main waiting area.

At this inspection we looked at how children were waiting.

- Children who attended for treatment were sent to a secure, separate waiting area to wait to be treated in the UTC.
- Staff told us they felt children who had been observed in January and were waiting in the main waiting room were most likely attending with parents who were awaiting treatment. They said any child needing treatment would always be directed to the paediatric waiting room where they would be seen as quickly as possible.

Risks to patients

During the inspection of the ED in January 2019, some clinical staff told CQC inspectors the Urgent Treatment Centre (UTC) sometimes closed at short notice at 10pm until the next morning due to a lack of clinicians. We reviewed staff rotas and systems to plan and manage these rotas at this inspection and asked staff if the service had closed as described.

At this inspection we found there were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand and for dealing with staff absence. Staff we spoke with told us the service had been suspended briefly for a period of approximately two hours once about two years ago because of extreme mitigating circumstances, when medical cover had been maintained by telephone. They told us apart from that one incident, the face-to-face service had never closed. They felt because the minor injury service offered by the UTC ceased at 10pm, there may have been a misunderstanding by ED staff.
- Fylde Coast Integrated Urgent Care Service (FCIUCS) had recruited additional reception point staff to ensure cover for this role was sufficient. Rotas for staffing the service were produced for two months in advance wherever possible and there were weekly conference calls between members of the FCIUCS to discuss the following week's staffing rota.
- There was an effective induction and introduction system for temporary staff tailored to their role. The provider allowed time for clinicians who were new to the service to be introduced to policies and procedures and be given all information necessary for their role. There was a detailed information pack and induction process for new staff. The provider used regular sessional GPs and locum staff and ensured safe staffing with a comprehensive clinical approval checklist.

The hospital inspection in January 2019 raised concerns related to the pathway protocols used by the FCMS reception point staff, suggesting the pathways were not always appropriate and did not enable staff to immediately recognise and appropriately stream patients with significant risks. There were concerns related to the training of reception point staff in the use of the assessment pathways.

At this inspection we found FCMS reception point staff had the knowledge and expertise to use the pathway assessment tools appropriately.

Are services safe?

- Staff on the Urgent Care Centre reception desk, or "Primary Care Gateway", used a national pathway tool to assess the severity of patient conditions and navigate patients to the appropriate treatment route; either to the UTC or the ED. They also used a navigation tool for patient minor injuries that had been developed between the services and was constantly reviewed.
- Reception point staff undertook intensive training to use the patient pathways. There was a requirement for six hours' pre-course reading, a full-time two-week course where learning was assessed with examinations, followed by at least four weeks shadowing existing, experienced staff. Staff had personal development plans in place and were monitored and supported throughout this process.
- FCMS had appointed a new service delivery co-ordinator in April 2019 to support staff. They were an accredited NHS pathways trainer who provided training and support to staff. We saw an improvement programme for staff development for 2019 that included case review workshops and pathways refresher training.
- Staff working on reception were audited monthly. A random three to five cases were reviewed by senior staff for each receptionist. There was supportive monitoring of audit results and further training given where necessary.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They had a good knowledge of emergency procedures and how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. There was a protocol in place to allow for patients assessed by reception point staff as needing more urgent assessment by the ED triage nurse to be identified and managed quickly. Staff had access to alarm buttons to summon immediate help in the event of an emergency.
- Systems were in place to manage people who experienced long waits and ensured the FCMS shift managers were aware of delays to treatment.
- Staff had access to interpretation services if needed for those patients whose first language was not English and there was information displayed about this.
- Staff working on the reception desk were supported if they needed further advice on the appropriate pathway of care for a patient. Following our inspection of the Urgent and Emergency Services at Blackpool Victoria Hospital on 7 January 2019, the ED department supplied an ED triage nurse to sit with members of the FCMS reception point team on the front desk permanently. There were always two members of FCMS reception staff on the desk who were supported by the shift manager, a nurse in the UTC (contacted by "bleep") and the ED triage nurse. Staff told us this had addressed previous concerns regarding the clinical supervision of the waiting room and had improved communication with the ED. Staff said they felt supported in their work and things were better since the ED nurse was on the reception desk.
- Patients with a minor injury directed to the waiting area following initial assessment by reception point staff, were given a short information sheet to explain care and treatment options.
- If reception staff directed patients to the UTC and it was found by the clinician that it would be more appropriate for the ED to offer treatment, there was a protocol in place to redirect the patient. We saw this happen during our visit when a GP from the UTC brought a patient back to reception for immediate ED triage. There were processes in place to ensure all electronic records already made were transferred from one service to the other. The protocol also allowed for transfer of patients from the ED to the UTC.
- The service monitored patients who were shown as navigated by reception to the UTC and then transferred to the ED. Each patient pathway was audited to see whether navigation by reception could be improved and common themes were identified. We saw an audit that showed a common theme related to the management of patient head injuries. As a result, the minor injury navigation tool for head injury was reviewed and amended. We also saw evidence of changes made to the navigation tool for patients with a hip injury as a result of review.
- We saw evidence of reducing numbers of patients who were directed by reception to the UTC and then transferred to the ED. In November 2018, 75.8% of patients who were transferred from the UTC to ED had come from the reception desk, in December 2018, 72%, in March 2019, 59.9% and then in April 2019 this had reduced further to 40.7%.
- Staff we spoke with on the reception desk were aware of lessons learned from the analysis of redirected patients and told us of changes made as a result.

Are services safe?

- FCMS staff had also audited those patients who had primarily been directed to the ED and returned to the UTC during January 2019. They identified common themes which were communicated to reception point staff and used for delivering targeted staff training.
- We were given evidence of a large body of audit work conducted in April 2018 that had been used to inform practice.
- We observed staff navigating patients to the most appropriate care and treatment and using the navigation tools available to them and saw no evidence of unsafe care.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Track record on safety

The service had a good safety record.

- The service monitored and reviewed activity particularly the use of the pathways and navigation tools used by reception point staff. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- Joint reviews of incidents were carried out with partner organisations, including the hospital ED, NHS 111 service and the North West Ambulance service.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The shift manager working at the Urgent Care Centre was required to complete a report at the end of each shift related to any incidents or issues that may have occurred. These were entered onto a central incident reporting system as required. Shift reports also contributed to action logs which detailed any outstanding action to be taken or learning points to be communicated.
- The FCMS clinical governance and complaints lead had arranged with the hospital Trust they would be the first point of contact for service-related incidents. They were able to enter details of new incidents directly onto the hospital incident reporting system and add updates to existing incidents.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. There was a reciprocal agreement with an external company which provided similar urgent care services, for independent review of serious untoward incidents. Incidents were discussed at staff and governance meetings and staff were informed of lessons learned through meetings, email correspondence and newsletters. There was a newsletter for non-clinical staff, “Lessons Learned”, issued every six weeks following FCIUCS clinical governance meetings. This detailed non-clinical incidents and complaints with lessons learned and any ongoing issues in need of communication. The clinical newsletter “Clinical Update” similarly detailed clinical issues with case studies, audits, best practice guidance and patient safety alerts.
- There was a comprehensive untoward incident and serious incident policy which clearly explained the process for the management of incidents.
- Clinical governance meetings had set agendas where incidents reported on the central incident reporting system were discussed.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. At the time of our inspection, a pathway of care for referrals from the Urgent Care Centre for patient mental health assessment developed between the providers of the urgent care services, Blackpool Teaching Hospital and Lancashire Care was about to be finalised for staff use.

Are services well-led?

Governance arrangements

Our inspection of the Urgent and Emergency Services (ED) at Blackpool Victoria Hospital on 7 January 2019 indicated a lack of suitable governance processes and procedures between the services associated with the Urgent Care Centre.

At this inspection, there were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. We saw evidence indicating improvements to governance structures and processes.
- FCMS had taken the lead for clinical governance and set agendas for governance meetings which took place monthly. These were chaired by the FCMS clinical governance and complaints lead and there were comprehensive minutes kept for these meetings and clear action plans which detailed individual responsibilities and dates for completion. We saw minutes of meetings that showed attendance from staff from all services involved in provision of services in the Urgent Care Centre with representation from the Police and Lancashire Care when relevant.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

There was an effective process to identify, understand, monitor and address current and future risks to patient safety.

The provider had processes to manage current and future performance of the service. Performance of reception point staff could be demonstrated through audit of their patient assessments using the pathways and navigation tools. Leaders had oversight of incidents and performance was regularly discussed at senior management and board level. There was an embedded meeting structure to support service development.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Minor injury navigation tools were reviewed regularly using audit of the outcomes of patient pathways through the Urgent Care Centre. There was a review of the national pathway tool every six months following national review.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. There was an established meeting structure to aid communication; non-clinical meetings were held every eight weeks, shift managers met every two weeks and multi-agency clinical governance meetings happened every month. Rotas for staffing the service were discussed weekly on a conference call between staff in the FCIUCS.
- There was regular communication with staff. FCMS staff produced a six-weekly newsletter, “Lessons Learned” for non-clinical staff and “Clinical Update” for clinical staff. There was also a care co-ordination newsletter for all staff detailing service developments, staff training and social messages.
- The service used performance information which was reported and monitored, and management and staff were held to account. There was regular monthly audit of reception staff patient assessments which was shared with staff, with supportive training or feedback when needed.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. A new service delivery co-ordinator had been appointed to improve areas of staff training and support and an ED triage nurse had been allocated to sit on the front reception desk to offer support.
- Staff knew about improvement methods and had the skills to use them.

Are services well-led?

- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.