City Health Care Partnership CIC - The Wolds Primary Care Practice

Quality Report

Entrance A
Bridlington Hospital
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Bridlington
North Humberside
YO16 4QP
Tel: 01262 423464
Website: http://minorinjuries.chcpcic.org.uk/pages/bridlington-urgent-treatment-centre

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

Key findings

Contents

Letter from the Chief Inspector of General Practice

This service is rated as Good overall. (Previous

inspection July 2016 – Good. In July 2016 all the population groups were rated good. The population groups were not inspected at this inspection as we only looked at the urgent treatment centre aspect of the service. The previous rating of good still apply).

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an unannounced focused inspection at The Wolds Primary Care Practice on 12 and 13 July 2018 in response to concerns that CQC became aware of in relation the to the Urgent Treatment Centre (UTC) aspect of the service.

At this inspection we found:

• The service had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the service investigated them and identified lessons and areas for improvement.

• The provider was developing a process for clinically assessing patients within required timescales when they attended the UTC, to enable them to meet the national NHS England Urgent Treatment Centres – Principles and Standards by March 2019.

• Staff had the knowledge, skills and competence to deliver care to patients.

• The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.

• Staff involved and treated people with compassion, kindness, dignity and respect.

• Patients could access care and treatment for their needs from the service between the NHS England

recommended opening times.

• There was a leadership structure but staff did not feel they could always access support from the

management team.

The areas where the provider **should** make improvements are:

• Continue to develop the process so patients are clinically assessed in line with NHS England: Urgent

Treatment Centres – Principles and Standards' by March 2019.

• Implement a system to monitor that access to GP advice is available to nurses/emergency practitioners when required.

• Improve communication and access between staff and the management team.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Summary of findings

Chief Inspector of General Practice

City Health Care Partnership CIC - The Wolds Primary Care Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector and included two other CQC Inspectors.

Background to City Health Care Partnership CIC - The Wolds Primary Care Practice

City Health Care Partnership CIC (CHCP) - The Wolds Primary Care Practice, Entrance A, Bridlington Hospital, Bessingby Road, Bridlington YO16 4QP is located two miles from the town centre in Bridlington Hospital. There is a GP Practice and an Urgent Treatment Centre (UTC) service provided from The Wolds Primary Care Practice – at this inspection we only reviewed the UTC part of the service. The practice is part of a large organisation, City Health Care Partnership CIC (the Provider), which is led by a senior regional operations team based in Hull.

There are local buses serving the hospital that come into the hospital grounds. There is a car parking available including disabled parking. There is disabled access and consulting and treatment rooms are all on the ground floor.

The Urgent Treatment Centre (UTC) service is commissioned by the East Riding of Yorkshire CCG. The service is open to non-registered patients and can be accessed by NHS 111 or by walking in without an appointment.

The UTC service is a nurse/emergency practitioner led service, practitioners have access to GPs for advice if required. There are some nurses/ emergency practitioners that are employed to work in The Wolds UTC and additional nurses/ emergency practitioners who do regular sessions to ensure there is enough cover to meet the needs of the service. Some are employed at other CHCP locations and some are long term agency staff. There is an operational manager and a team of receptionists.

The UTC service is open between 7am to 11pm seven days a week, 365 days a year.

Information about the opening times is available on the website and in the UTC leaflet.

Good

Are services safe?

Our findings

We rated the service as good for providing safe services.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

• The NHS contract for the service had changed in April 2018 resulting in the service being open from 7am to 11pm instead of 8am to 9pm. The general manager we spoke with said historical data and information prior to April 2018 was used to determine staffing levels for the additional three hours they would be open. The provider also used a computerised rostering tool to determine adequate staffing levels.

• We saw examples where children under the age of one had been sent to the Urgent Treatment Centre (UTC) by NHS 111 in error or parents would bring them to the UTC. When these incidents occurred, staff reported them and where relevant the provider forwarded them to NHS 111 for them to investigate. Staff had the knowledge and skills to deliver care to patients including children. All staff were trained to enable them to respond to emergencies if they occurred, including whilst children may be waiting for transfer to another service. The patient information leaflet that had been produced by the local CCG and the provider's website did not make it clear that children under one year old could not be seen in the UTC. We discussed this with the provider during the inspection.

• We reviewed the staff rotas from 4 April 2018 to 30 June 2018 and there were two occasions in April, three in May and five in June when there was only one nurse/emergency practitioner on duty between the hours of either 7am to 10am or 8pm to 11pm. Staff told us there should have been two staff on duty at these times. The provider sent information following the inspection that showed that there were only four occasions between 1 April and 2018 and 30 June 2018 when there was only one nurse/emergency practitioner on duty. The provider told us that GPs were co-located in the department or available on the phone. However, staff we spoke with said that GPs were not always present and they could not always access advice on the phone. We observed during the inspection that a patient waited one hour and 40 minutes to see the OOHs GP as they were not present between 6pm and 7pm. We found that staff reported staffing issues through the incident reporting system and this was a risk that had been identified on the providers risk register. However, it was unclear what actions had been taken to resolve this.

• The provider's business continuity plan outlined the process for dealing with any surges in demand. The general manager told us they monitored activity and when it got to a specific level they would review if enough staff were available to meet the demand. Staff in the urgent treatment centre told us they were not always able to access the management team based in Hull to escalate issues with demand.

• Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. There was a prioritisation protocol for receptionists to use to assist in identifying patients with the most urgent needs. If patients presented with an urgent condition the receptionist sent a message via the clinical record system to let the clinician know. However, they did not go and tell the clinician in person which could have resulted in a delay in them responding.

• The NHS England: UTC – Principles and Standards' state patients that did not have a booked appointment should be clinically assessed within fifteen minutes of arrival and those with a pre-booked appointment made by NHS 111 had to be seen and treated within 30 minutes of their appointment time. The provider was developing a process to enable them to clinically assess patients within required timescales to meet the NHS England: Standards' by March 2019'. Two health care assistants who had recently joined the service were due to complete competencies by the end of August 2018 in carrying out initial assessments of patients.

• There was a notice on the reception desk advising patients to inform the reception staff if they felt unwell or their condition deteriorated whilst waiting to be seen, however, staff did not tell patients to do this when they booked the patients in.

• When required nurses/emergency practitioners were able to seek advice from GPs that worked in the adjacent GP practice and in the out of hours service at Bridlington. However, when the practice was closed the staff told us out of hours GPs were not always present in the building. However, they could ring a GP at one of the other UTCs but it could be difficult for them to access advice from a GP.

Good

Are services safe?

Nurses/emergency practitioners knew how to identify and manage patients with severe infections, for example sepsis.

• Staff told patients when to seek further help. They advised patients what to do if their condition got worse after leaving the UTC.

• The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. During the inspection there were no records available to show that emergency equipment was checked regularly to ensure it was working. Following the inspection, the provider sent evidence that these checks had been completed.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

• Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

• Some of the nurses/emergency practitioners were prescribers, when there wasn't a prescriber on duty nurses/ emergency practitioners used patient group directions to enable them to administer medicines in line with legislation.

Track record on safety

The service had a good safety record.

• There were comprehensive risk assessments in relation to safety issues.

• The service monitored and reviewed activity. 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 local A&E department, GP out-of-hours, NHS 111 service and urgent care services.

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.

• 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. For example, the wrong dose of medication was prescribed for a patient with an infection. This was fed back to the practitioner concerned and all clinical staff were reminded of the relevant guidelines for prescribing.

• The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the service as good at our inspection in July 2016, this rating still applies for providing effective services.

Monitoring care and treatment

We saw examples of audits that had been completed to assess the clinical practice and decision making of nurses/ emergency practitioners. Re-audits had been completed to check that areas for improvement had been addressed.

Effective staffing

Staff had the skills, knowledge and experience required to carry out their roles.

• All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. There was a comprehensive competency framework in place which covered topics such as chest symptoms, ankle and foot injuries and rashes.

• The provider ensured that all staff worked within their scope of practice. However this was sometimes challenging as children under the age of one would be sent to the UTC by NHS 111 in error or parents would bring them to the UTC. When these incidents occurred, staff reported them and where relevant the provider forwarded them to NHS 111 for them to investigate.

• The provider was aware of the need for additional training in the treatment of children for nurses/emergency practitioners across all their UTCs. They had an agreement in place with the local Trust for nurses/emergency practitioners to go to paediatric departments to shadow and observe. Two advanced nurse practitioners were doing an Advanced Clinical Practice for Community Paediatrics course.

• The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

• The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

Good

Are services caring?

Our findings

We rated the service as good at our inspection in July 2016, this rating still applies for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.
- All of the three patient questionnaires we received were positive about the service experienced. This was in line with the results of the NHS Friends and Family Test feedback received by the service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the service as good at our inspection in July 2016, this rating still applies for providing responsive services.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The service operated from 7am to 11pm seven days a week, 365 days a year.
- Patients could access the service either as a walk in-patient, via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment. The patient information leaflet encouraged patients to 'talk before you walk' and contact NHS 111 before attending the urgent treatment centre. This was to enable patients to be signposted to the most appropriate service for treatment of their illness or injury.
- Patients were generally seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The UTC service did not see patients under one years of age and we observed the receptionist responding positively to a five-week-old baby brought in with a rash. The receptionist spoke to the OOHs GP and arranged for the baby to be seen meaning the parent did not have to leave and phone NHS 111 to arrange for the baby to be seen in the OOHs service.
- The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.

The service shared with us the performance data from 1 April 2018 to 30 June 2018 that showed:

- 99% of people who arrived at the service were seen within four hours. This was better than the national target of 95%.

Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Are services well-led?

Good

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

Our findings

We rated the service as good at our inspection in July 2016, this rating still applies for well led.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

• Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges, for example the issue with staffing levels was on the organisation's risk register which was discussed at the monthly Directors meeting.

• We received mixed feedback from staff about management support. The team leader for the UTC had recently left the service. Staff told us they had been well supported by their team leader that had left. However, they now felt that the management team was not always accessible throughout the operational period and the on-call system that staff used to access management support out of hours was not fully effective. Other staff told us they felt well supported and the management team had come to the UTC to introduce themselves and meet with staff.

• The provider had recently re-structured its management team but the impact of this in terms of improvements for staff working in the UTC was not yet evident.

Vision and strategy

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

• There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.

• The service developed its vision, values and strategy jointly with patients, staff and external partners. Consultations had been undertaken as part of the decision to re-structure the urgent care provision for Bridlington and the surrounding area.

• Staff were aware of and understood the vision, values and strategy and their role in achieving them.

• The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.

• The provider monitored progress against delivery of the strategy.

• The provider had not ensured that staff who worked away from the main base always felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

• Some staff did not feel fully respected, supported and valued.

• The service focused on the needs of patients.

• Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

• Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. There was a mandatory question on the incident reporting system that asked if the duty of candour was relevant.

• Staff we spoke with told us they were able to raise concerns and were encouraged to do so. However, they did not have full confidence that these would be addressed, for example staffing.

• There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. They also said they had good access to training and courses that they wanted or needed to do.

• Clinical staff, including nurses, were considered valued members of the team by managers and there was a strong emphasis on the safety and well-being of all staff. However not all staff felt this was the case.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Are services well-led?

Good

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

• 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.