# Corby Urgent Care Centre

## Quality Report

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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 |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Corby Urgent Care Centre on 9 March 2017. Overall the centre is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. However there was room for improvement in relation to dissemination of learning from incidents.
- Risks to patients were assessed and well managed and the practice sought to continually improve processes, including through escalation processes.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The centre had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The provider proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- Clinicians sort patient's views and involved them in decisions about their care. This meant patients had input into their condition management plans as a strategy to help empower them to improve their health.
- There was a focus on continuous learning and improvement. This included through multidisciplinary working to provide staff with emergency care training and with a local ambulance service to ensure appropriate patient access.

# Summary of findings

- Clinical staff had access to a digital 'app' that enabled them to see the demand on the centre and current staffing levels at any time. This meant staff could offer to provide extra cover during times of exceptional demand.

There was an area where the provider should make improvements:

- The centre should implement a system to ensure all staff are made aware of learning from significant events.

There was an area of outstanding practice:

- In the 12 months prior to our inspection, the centre achieved a 94% avoidance in hospital admissions, this was due to effective use of the Manchester triage scores.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The centre is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events. However, investigation and dissemination processes for significant events were inconsistent and there was limited evidence that all staff were included in learning outcomes.
- There was evidence the centre acted on national patient safety alerts and alerts from the Medicines and Healthcare Products Regulatory Agency. However, there was room for improvement to the system used to ensure all members of staff were updated.
- When things went wrong patients received reasonable support, information, and a written apology.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. The clinical team monitored safeguarding referrals on a monthly basis as a quality assurance process to identify areas for improvement in referral processes.
- Medicines management processes were in place including repeat prescription monitoring, emergency drugs checking and a safety alerts protocol.
- Appropriate levels of infection control practice were in place and monitored through regular audits, including a monthly hand hygiene audit. Where areas for improvement were identified, the senior team implemented and monitored these.
- Electronic monitoring processes were in place to ensure staffing levels were adequate for the demand on the centre, which could be increased at short notice. This formed part of an established escalation process that meant patients were managed based on their level of risk and urgency of need for care.

**Are services effective?**

Good

The centre is rated as good for providing effective services.

- Staff used national clinical assessment tools to triage patients and ensure the most appropriate care was provided.
- Staff assessed needs and delivered care in line with current evidence based guidance and used a weekly review system to ensure they were always to date with latest standards and guidance.

# Summary of findings

- A nurse clinical advisor was based in the centre to conduct clinical audits. We saw evidence of improvement in practice, training and staff support as a result of audits.
- The centre had a target of no more than 100 patients per month be sent back to their respective GP or recommended self-care as a result of their attendance. Between April 2016 and January 2017 the centre performed variably in this measure, with an average of 107 referrals per month. This reflected a range of between 79 and 150 per month.
- Between April 2016 and January 2017 the centre experienced lower rates of reattendance at the centre than the maximum key performance indicator.
- Clinical audits and benchmarking exercises demonstrated quality monitoring and improvement. The centre had a demonstrable track record in identifying areas of good practice in patient care, opportunities for multidisciplinary working and areas for improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. This was because there was a consistent, embedded culture of promoting professional development through extended clinical training.
- There was evidence of appraisals and personal development plans for all staff that demonstrated the commitment of the senior team to building on the skills and interests of each individual.
- Multidisciplinary working was used proactively to improve patient outcomes. This included working with a hospital emergency department and paramedics to implement an emergency care certificate training programme for staff.

**Are services caring?**

Good

The centre is rated as good for providing caring services.

- Data from the centre's latest patient survey showed a broad level of satisfaction with the service amongst patients.
- Feedback CQC comment cards indicated patients were treated with compassion, dignity and respect.
- The practice actively encouraged patients to be involved in decisions about their care.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient confidentiality.
- Structured emotional support was in place for patients including rapid access to mental health crisis teams.

# Summary of findings

**Are services responsive to people's needs?**

Good

The centre is rated as good for providing responsive services.

- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility, choice and continuity of care. This included flexible and urgent access and significant proactive work to ensure patients with complex needs had access to rapid, specialist care and support.
- The involvement of other organisations and the local community was embedded in service planning and ensured the practice met people's needs. This included working with the local ambulance service and hospital emergency department (ED) to reduce pressure on those services. For example, between April 2016 and January 2017, the ambulance service diverted 319 patients from an ED visit to the urgent care centre.
- There was a track record of responding to individual and complex needs, including when they were outside of the immediate area of the centre. This included intervention to help a homeless patient access vital services such as a food bank and housing.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances.
- The centre achieved three out of four key performance indicators in relation to patient access and waiting times between April 2016 and January 2017. For example, 0.4% of patients waited over four hours to be seen against a target of 5%. In addition, 62.8% of patients were triaged within 15 minutes against a target of 95%.
- The centre was equipped to treat patients with urgent care needs. This included x-ray and diagnostic facilities and a plaster room.
- The centre had observation bays that staff used to monitor patients. Patients could stay here during opening hours and could be transferred to hospital through an agreement with the local ambulance service if their condition deteriorated or they needed overnight observation.
- There was active review of complaints by the centre manager and clinical director and improvements were made as a result across the services. Patients were invited to be involved in the review of their complaint.

**Are services well-led?**

Good

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

# Summary of findings

- Leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.
- The leadership team identified 'excellent care' as a key part of the service strategy and told us about plans to further develop their service, including capacity to treat more complex acute illness in the future, including new scanning and diagnostic equipment.
- Governance and performance management arrangements were proactively reviewed and involved the whole team, such as in the implementation of a performance monitoring 'dashboard' to help staff identify good performance and weaknesses in the system.
- There were high levels of staff satisfaction. Staff were clearly proud of the organisation as a place to work and spoke highly of the culture. The leadership team facilitated consistently high levels of constructive engagement with staff and patients.

# Summary of findings

## What people who use the service say

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards, 24 of which were positive about the standard of care received. Fifteen patients commented on the ease of accessing the centre, including the speed of triage, diagnosis and treatment.

Eleven patients commented specifically on the professionalism and welcome they received from staff, including receptionists. One negative commented related to a triage delay of 30 minutes and that the patient could not easily see the electronic display used to call each patient to their appointment.

## Areas for improvement

**Action the service SHOULD take to improve**

- The centre should ensure there is a system in place to ensure all staff are made aware of learning from significant events and the senior team are assured changes to practice are implemented.
- The centre should ensure there is an effective system in place to ensure all staff are aware of updates to practice as a result of national patient safety alerts and alerts from the Medicines and Healthcare Products Regulatory Agency.

## Outstanding practice

- In the 12 months prior to our inspection the centre achieved a 94% avoidance in hospital admissions.
- The clinical director was lead author for the Royal College of Surgeons of Edinburgh's Diploma in Urgent Medical Care (DUMC) and seven members of the clinical team were nominated as DUMC examiners.

# Corby Urgent Care Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and a second inspector supported by a GP specialist adviser.

## Background to Corby Urgent Care Centre

Corby Urgent Care Centre is operated by Lakeside Limited in a purpose built facility and is a GP-led centre focused on early decision-making for patients presenting with symptoms or an illness.

A team of 30 staff provide the service, led by a GP clinical director. There are three salaried GPs, seven nurse practitioners, four healthcare assistants and four urgent care technicians. A matron and centre manager provide day-to-day leadership and a team of dedicated receptionists and administrators support the service.

The centre is open seven days a week between 8am and 8pm and provides services to patients regardless of whether they are registered with a GP. Three GPs provide the service on a Monday and two GPs provide the service Tuesday to Sunday. Two nurse practitioners are available daily and a team of urgent care technicians provide clinical support in phlebotomy, bloods and cannulation.

The centre has eight consulting rooms, two treatment rooms including a resuscitation room, two triage rooms, a plaster room, x-ray and diagnostic facilities and 12 observation couches. There are three four-bedded observation bays for treatment investigation and clinical observation and staff can arrange transfer to hospital through the local ambulance service if overnight observation is needed.

The centre accepts medical students and provides a seven-day training block for clinical competency development.

Between April 2016 and January 2017 the centre saw 58,727 patients and conducted 21,361 diagnostic tests.

The centre is readily accessible for people who use wheelchairs and by parents with pushchairs. A portable hearing loop system is available and there are quiet waiting facilities for patients who find the main waiting area can cause anxiety. Private space is available for breast-feeding. There is step-free access to all clinical areas, facilities for bariatric access, waiting areas and a coffee shop.

We had not previously inspected Corby Urgent Care Centre.

## Why we carried out this inspection

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

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 March 2017.

During our visit we:

- Spoke with a range of staff from the clinical and non-clinical teams, including the centre manager and clinical lead.
- Observed how patients were being cared for and reviewed feedback provided from CQC comment cards.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed audits and documentation relating to safety and quality assurance.

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

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

Please note that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time.

Good

# Are services safe?

## Our findings

**Safe track record and learning**

There was an effective system in place for reporting, investigating and recording of significant events, however we identified some gaps in dissemination of learning outcomes.

- There was an effective system in place for reporting and recording significant events, however there were gaps in investigating and disseminating learning outcomes.
- One significant event involved a patient transferred to the local emergency department following a GP completing his shift without re-evaluating a patient. The incident had been fully investigated and subsequently discussed at clinical governance meetings held February and March 2017. Following closure of the matter, the senior team agreed that discussion should be held with the individual GP only as it was determined that this was an individual error rather than a systems failure. We saw no evidence to show further dissemination and learning had been shared with other staff members. Although an action plan was in place there was no evidence this had been completed, shared or disseminated with the centre team.
- The second significant event we reviewed was in relation to a child safeguarding issue raised by a GP at the centre to raise awareness where wider external systems and process appeared not to have taken place. This was subsequently discussed at two clinical governance meetings held December 2016 and February 2017 where it was agreed to liaise with external organisations to confirm that correct policies and procedures were in place. However we saw no evidence to show further dissemination and learning had been shared with other staff members.
- Between April 2016 and January 2017, the centre logged 33 significant events.
- The centre manager, whose role was clinical, investigated incidents as part of the clinical governance policy and escalated serious incidents to the directors. We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- All staff attended a three-monthly significant event review meeting to discuss the progress of investigations and learning outcomes. However, nurses told us they were only included in the findings and learning from significant events if a change of policy or practice was implemented as a result and a GP we spoke with could not identify any changes to practice or policy as a result of a significant event. This meant the system in place to ensure that each member of the team was included in investigation outcomes was not fully effective.
- We reviewed safety records, patient safety alerts and minutes of meetings where these were discussed. For example, when a patient safety alert had been issued with regards to a newly identified risk for patients with cartilage ear piercing, the senior team disseminated the new information and policy guidance to all clinical staff. We also saw evidence that patient safety alerts, including medicine alerts issued by the Medicines and Healthcare Products Regulatory Agency (MHRA) were recorded and appropriate action taken as necessary.

**Overview of safety systems and processes**

The centre had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The matron and a nurse practitioner were the designated leads for safeguarding adults and children and there was always a safeguarding lead available when the practice was open.
- All GPs, nurses and urgent care technicians were trained to an appropriate level to manage adult and child safeguarding (level three).
- The provider monitored the outcomes of safeguarding referrals as part of the clinical governance and quality process. For example, between June 2016 and February 2017, staff made 22 safeguarding referrals. Of these, 10

were found to not meet the referral criteria for the service they were referred to. We saw from looking at the minutes of governance meetings that safeguarding referrals were a standing agenda item and the senior team provided continual support to staff on using referral criteria.

- All staff met each morning for a daily safety brief before the centre opened. The team used this to discuss the operational plan for the day, any issues from the day before and to review staffing levels and skill mix.
- The urgent care centre shared the building with a GP practice, whose staff could refer patients if they needed urgent care. Established systems were in place to maintain the clinical safety of these patients whilst they were waiting and if they needed extra attention, such as if their condition deteriorated. For example, if a GP from the practice that shared the building brought a patient to the centre to wait for an ambulance, a handover took place to ensure there was a responsible person available for the patient if their condition deteriorated.
- Patients admitted to the observation bay were cared for using a specific protocol. This included the need for a handover between staff and a series of clinical observations documented within five minutes of the handover. We saw this occurred consistently in practice from our observations and review of records.
- Staff were trained in the use of the Department of Health reporting procedures for female genital mutilation and this was readily available through the staff intranet.
- A notice on the reception desk and on the electronic display screen in the waiting area advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The centre maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was evidence privacy curtains in treatment bays had been changed every six months. There was an infection control protocol in place that involved the completion of a daily cleaning log by the centre manager and a monthly audit of this.
- There was evidence the matron took action when infection control and hazardous waste procedures were not followed. For example, when the matron found sharps bins filled past the safe fill mark and will inappropriate waste inside, a briefing was sent to all members of staff.
- The leadership team maintained a record of staff immunity status and a register of staff vaccinations. This had been audited in 2017 and all staff were up to date with necessary treatment.
- The arrangements for managing medicines, including emergency medicines and vaccines, kept patients safe. This included obtaining, prescribing, recording, handling, storing, security and disposal of medicines.
- The practice had medicine fridges and all had digital temperature monitoring devices. Staff monitored temperature recording of the fridges to ensure they maintained a temperature within medicine manufacturers' safe guidelines and we saw this was documented on a daily basis. In all examples we saw temperatures were within safe ranges.
- An up to date prescribing policy was in place and ensured clinical staff prescribed within the scope of the service. For example, the centre did not offer repeat prescriptions and medicines administered were recorded in patient care records.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. All of the PGDs we checked were in date, correct and signed.
- The centre carried out background and qualification checks on locum doctors and ensured each individual completed an induction before being able to practice. We looked at the induction process as part of our inspection and found it included an introduction to the safety procedures of the centre and emergency equipment.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. This included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.
- The triage system ensured all patients were initially seen by a nurse practitioner or a GP who assessed their immediate need and level of risk. Clinical staff used an electronic monitoring system to track waiting times in the centre and implement risk management plans for individual patients if needed. This formed part of the escalation process. For example, during an

Good

# Are services safe?

exceptionally busy Sunday the centre received 23 patients within 40 minutes leading to a queue of 25 patients waiting for triage. In response the clinical team restructured the triage service, redeployed nurse practitioners and called in the matron in accordance with the standard operating procedure.

**Monitoring risks to patients**

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and a designated health and safety lead was in post. Reception staff were trained as fire marshals and the centre manager was the designated fire officer. The centre had up to date fire risk assessments and carried out a practice evacuation every six months. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. A risk assessment and test for legionella had been completed in March 2017 and the building was found to be safe. Legionella are bacteria that can contaminate water systems in buildings.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. We saw this meant the centre was appropriately staffed.
- Staff used an electronic records system to document observations of patients admitted to an observation bay. This included hourly observations and a discharge summary.
- The practice held stocks of controlled drugs (CDs) and a clinical member of staff documented daily stock checks on these. CDs are medicines that require extra checks and special storage because of their potential misuse. The centre had procedures in place to manage them safely, including arrangements in place for the destruction of controlled drugs. This included daily checks of the CD register, which was cross-checked by two members of clinical staff.

**Arrangements to deal with emergencies and major incidents**

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

- There was an instant messaging system on the computers in consultation rooms and reception that alerted staff to an emergency.
- All staff received annual basic life support training and there were emergency medicines available on-site, including in two emergency grab bags. The grab bags could be used for clinical staff to respond to emergency situations in and around the centre and staff demonstrated knowledge of their location and use.
- The centre had a resuscitation room with resuscitation medicine and fluids, oxygen with masks for children and adults and two automatic defibrillators. An emergency grab bag was available with clinical equipment for giving blood and fluids and also included a defibrillator. A first aid kit and accident book was available. Documented daily safety checks were thorough and included each individual item of equipment as well as medicine stocks and expiry dates and the resuscitation room as a whole.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- In the event of an incident that stopped the service, the information manager was responsible for leading contingency plans. This included establishing a major incident centre and delegating tasks to staff based on an escalation plan. Staff had completed a simulated exercise with the local CCG and identified areas for learning, such as how to coordinate a media response.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were kept at the main surgery and the branch practice. All of the staff we spoke with demonstrated detailed knowledge of their actions and responsibilities in a major event.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

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

- Clinical decision making was managed by a GP-led triage service that used the Manchester Triage System and the Paediatric Observation Priority Score. This meant patients were seen by a clinician who used an evidence-based system to determine the best course of action to take.
- Staff delivered care based on a series of standard operating procedures (SOPs) that were evidence-based and included clinical guidance for specific conditions, population groups or treatment such as foetal Doppler and paediatric pain relief. We looked at a sample of SOPs and found them to have been reviewed within the previous 12 months and each member of clinical staff had signed them.
- We saw some examples of how care and treatment was provided in line with national best practice guidance. For example, including that issued by NICE in relation to the management of sepsis and emergency care guidance issues by the Resuscitation Council (UK).
- The practice had systems in place to keep all clinical staff up to date with national guidance. This included a weekly meeting to review changes to guidance from NICE.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The centre had a target of no more than 100 patients per month be sent back to their respective GP or recommended self-care as a result of their attendance. Between April 2016 and January 2017 the centre performed variably in this measure, with an average of 107 referrals per month. This reflected a range of between 79 and 150 patients per month.

**Management, monitoring and improving outcomes for people**

There was evidence of quality improvement including clinical audit.

- The centre demonstrated positive impact on the local population and health outcomes through a 94% overall avoidance in hospital admissions and a 78% reduction in emergency department attendance for adults and 80% avoidance for children. Staff achieved this through effective use of the Manchester Triage Scores.
- The centre team presented their model of care as an example of leading-edge practice at the 2016 Royal College of General Practitioners Conference. This formed part of a broad track record of service development and benchmarking through ongoing staff development. For example, the clinical director was lead author for the Royal College of Surgeons of Edinburgh's Diploma in Urgent Medical Care (DUMC) and seven members of the clinical team were nominated as DUMC examiners. This examination will act as the national gold standard assessment of competencies relating to the delivery of the urgent and unscheduled care that comprises the majority of NHS access time.
- Audits were used to benchmark local practice against national best practice guidance. For example, the centre participated in the Royal College of Emergency Medicine (RCEM) vital signs audit. In December 2016 an audit was undertaken of 50 patient records, which showed staff took appropriate action on finding abnormal vital signs in nine out of 14 cases. The centre also participated in the RCEM pain in children audit. In October 2016 the audit highlighted a fast response to providing children with analgesia.
- Between April 2016 and January 2017, unplanned re-attendance accounted for between 2.61% and 4.22% of monthly activity. This reflected an overall average unplanned re-attendance rate of 3.2%, which was better than the maximum target of 3.5%. This meant patients were at reduced risk of re-admission because staff accurately identified and addressed their medical needs at the time of the appointment.
- A clinical advisor was based in the centre to conduct clinical audits. We saw evidence of improvement in practice, training and staff support as a result of audits. For example, an audit of records highlighted a relatively high level of antibiotic prescribing for one member of staff. In response the senior team provided the individual with more support in accessing and interpreting the centre's formulary and antibiotic prescribing guidelines. There was evidence this resulted

in improvements in prescribing. For example, between March 2016 and February 2017 a further clinical audit identified a 61% reduction in the prescribing of co-amoxiclav; a type of antibiotic.

- Staff used a child pain score system through a pictorial template that enabled children to express their level of pain by pointing to cartoon faces. Visual communication aids for identifying levels of pain and need were also available for patients with learning disabilities.
- Reception staff were trained to identify deteriorating patients and to recognise signs of acute illness. In such circumstances reception staff would contact the clinical team or 999 as a priority.

**Effective staffing**

Staff had the skills, knowledge and experience to deliver effective care and treatment and there was a demonstrable track record of leadership in education, both in-house and in the community.

- The centre had an induction programme for all newly appointed staff, including locum doctors. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Initial and refresher training included safeguarding, fire safety awareness, and basic life support and information governance.
- All staff undertook an annual training refresher programme that included life support training. The GP clinical director conducted scenario training for all staff based on case studies, such as a baby who arrived in the centre in cardiac arrest.
- Nurse practitioners had access to regular training and clinical competency updates to ensure they remained up to date with best practice. The team identified areas for training based on patient needs and worked with the clinical director to ensure their skills met patient demand.
- The senior team recognised the benefits of ongoing training and development opportunities for staff. For example, the centre manager implemented protected learning time for nurse practitioners every six weeks. This enabled them to receive more frequent supervision from GPs and the opportunity to maintain and update clinical competencies. In addition an urgent care technician (UCT) had begun an accredited leadership programme to help them develop their skills and responsibilities in the centre. All UCTs had begun studying for the national care certificate as a strategy to maintain professional development.
- An education and training lead was in post and the clinical team had completed two study days in the previous year that included an update on life support training.
- We saw the centre team provided proactive feedback to the supervisors of medical students and worked with them to improve monitoring and support structures when student performance was unsatisfactory.
- The senior team had established a training programme with a hospital emergency department and paramedics to enable staff to study for the emergency care certificate.

**Coordinating patient care and information sharing**

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

- The centre had a national performance indicator that at least 95% of patient care summaries would be sent to the patient's GP by 8am on the next working day following their attendance. Between April 2016 and January 2017 the centre achieved this target in each month with an overall average of 97%. This included care and risk assessments, care plans, medical records and investigation and test results. A daily duty arrangement was in place to ensure pathology results and other referral documents were reviewed and acted upon in a timely manner.
- Staff worked closely with colleagues at nearby Lakeside Health Centre to ensure patients referred between the two services experienced a seamless service with no avoidable delays due to documentation.
- Clinical staff demonstrated effective referral pathways and working relationships with specialist teams, including in urgent situations. For example, a community mental health crisis team was available where a GP or nurse was concerned about a patient's immediate mental health and the centre had previously facilitated urgent visits from this team. An NHS child and adolescent mental health service (CAMHS) team was also available locally and at short notice.

Good

# Are services effective?

## (for example, treatment is effective)

- X-rays were available within one hour of request by a clinician and we saw clinical staff could refer patients directly to a local fracture clinic. Staff documented such referrals and sent these directly to the fracture clinic.

**Consent to care and treatment**

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. MCA training was provided in-house to the practice and multidisciplinary teams and MCA meetings were held on a responsive basis to meet the needs of individual patients.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. All clinical staff had training in the Gillick competencies and guidelines, which are frameworks to allow clinical staff to establish the capacity and ability of young people under the age of 18 to make informed decisions about their care.
- During our inspection we observed reception staff asked patients for their consent before viewing personal records and entering details into the electronic patient records system.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support. For example:

- Staff encouraged patients to seek follow up care with their own GP and to manage health through healthy living strategies. This reduced the need for patients to attend planned follow up appointments in the centre and between April 2016 and January 2017 an average of 1.3% of monthly activity related to planned follow ups. This was significantly better than the maximum monthly target of 2.75%.

Good

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

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

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

During our inspection we observed staff were able to respond quickly to patient's needs with compassion and discretion. For example, the nurse practitioner worked with one patient who was experiencing a mental health crisis to find a quiet space for them to sit, offered them a drink and contacted the local crisis team. The nurse also identified the patient was particularly anxious around certain members of staff. By spending time talking with them thee nurse identified the patient felt more comfortable with female staff. To ensure they were only ever seen by a female member of staff, the nurse added an alert to the patient's record.

Of the 25 patient Care Quality Commission comment cards we received, 24 were positive about the service experienced. Patients said they felt the service offered was of a high standard and highly responsive to their needs. Comments included the welcome received from receptionists and the professional attitude of doctors. Some patients also commented on the easy accessibility of the centre and said it offered them an alternative to attending a hospital emergency department or waiting for a GP appointment. One negative comment related to a triage delay of 30 minutes and that the patient could not easily see the electronic display used to call each patient to their appointment.

The centre undertook a patient satisfaction survey in July 2016 and August 2016 amongst 373 patients. This represented a response rate of 29% based on the number of patients in the centre at the time of the survey:

- 98% of patients said they were greeted in a friendly manner.
- 99% of patients said they were treated with respect.
- 99% of patients said staff had behaved in a professional manner.
- 98% of patients said they were satisfied overall.
- 98% of patients said they would recommend the centre to friends and family.

**Care planning and involvement in decisions about care and treatment**

Patient feedback from the comment cards we received was positive and noted patients felt they received individualised care. We saw that treatment plans were personalised.

Clinical staff proactively shared decision making with patients. This meant patients had input into condition management plans as a strategy to help empower them to improve their health.

Results from the centre's internal patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment:

- 95% of patients said their diagnosis was explained to them.
- 96% of patients said their treatment and medicine was explained to them or was not applicable in this case.
- 95% of patients said they were given the opportunity to ask questions.

**Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

Staff were able to refer patients to mental health support and crisis teams where they presented with an immediate risk or need.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The centre reviewed the needs of its local population and engaged with the Corby Clinical Commissioning Group (CCG), ambulance service and hospital emergency department to ensure services could meet demand.

- The centre was well equipped to provide urgent care services for patients with mental health needs and learning disabilities. This included a rapid referral arrangement to specialist teams and staff with the skills and knowledge to provide immediate care and de-escalation of crisis situations.
- Clinical staff had access to a digital 'app' that enabled them to see the demand on the service and current staffing levels at any time. This meant staff could offer to provide extra cover during times of exceptional demand to ensure the centre remained safe.

**Access to the service**

The centre was open seven days a week from 8am to 8pm.

A joint triage system was in place led by a GP and a nurse practitioner (NP). This system was flexible to the needs of patients and both GPs and NPs could operate triage independently at times of high demand. Clinical staff could redirect patients to a nearby GP walk-in clinic if they were identified as not needing urgent care.

The centre worked with the East Midlands Ambulance Service (EMAS) to divert patients from hospital emergency departments (EDs) to the centre if paramedics identified they could be treated safely there. Between April 2016 and January 2017 319 patients were seen in the centre as a result of an EMAS diversion. In addition the centre worked to a key performance indicator that no more than 2.5% of patients each month would be referred onward to a hospital ED. Between April 2016 and January 2017 the centre achieved this in two months and had an average referral rate of 3.1%.

A standard operating procedure was in place in relation to access to the centre. As part of this the nurse in charge would speak with each patient during times of exceptional demand to ensure they were aware of the waiting times and that they understood the triage system prioritised patients with the most urgent need. This meant patients who did not need to be seen urgently could be seen more appropriately elsewhere, such as in a pharmacy.

The centre monitored performance against a number of key performance indicators to establish its responsiveness to patient needs. Between April 2016 and January 2017:

- The centre monitored the number of patients who left before being seen against a monthly maximum target of 5%. Between April 2016 and January 2017 the centre performed better than this target in every month, with an overall average of 3.3%.
- An average of 0.4% of patients waited over four hours to be seen. This was significantly better than the monthly target of 5%.
- 62.8% of patients were triaged within 15 minutes. This was lower than the target of 95% and reflected variable performance ranging from 40.9% of patients in December 2016 to 79.7% of patients in August 2016. In response the centre had introduced more flexible working patterns that enabled the triage system to be modified and additional staff called in during times of high demand.
- The average time to treatment was 33.9 minutes, which was significantly better than the maximum monthly target of 60 minutes. The centre performed better than this target in every month in this period.

During this period results from the patient satisfaction survey indicated 93% of respondents were happy with the waiting time. During the time of data collection the average waiting time was 10 minutes.

**Listening and learning from concerns and complaints**

Posters in the waiting area explained the complaints procedure, which was also readily available on the centre's website. The centre received 52 complaints between April 2016 and February 2017, of which 48 related to clinical treatment or the approach of staff. In each case patients received an apology and explanation.

- We reviewed minutes of staff meetings found the senior team proactively discussed complaints, including investigations and outcomes.
- The senior team involved patients in the complaints process. For example, the centre manager invited a

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

complainant into the practice to discuss the diagnosis process and explain a misunderstanding in relation to this. They also ensured a printed summary of the meeting was sent to the patient afterwards.

- We saw that information was available to help patients understand the complaints system

We looked at all complaints received in the last 12 months and found in each case the practice manager documented a review and action. This included evidence of the initial action taken in each case and what they did afterwards to improve the service. For example, following a complaint from a patient with regards to a delayed x-ray, the centre improved communication to patients about the opening times and accessibility of the diagnostics service.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

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

- The centre had a mission statement which was displayed in the waiting areas and staff knew and understood the values. Each member of the team had the opportunity to contribute to the mission statement and vision of the practice we and saw they were passionate about its success.
- Staff identified 'excellent care' as a key part of the service strategy and said they hoped to introduce capacity to treat more complex acute illness in the future, including new scanning and diagnostic equipment. This was in the future planning stage at the time of our inspection.

**Governance arrangements**

The centre had an overarching governance framework which supported the delivery of the strategy and good quality care. This ensured that:

- The centre manager and senior team met to discuss the quarterly quality report, which included a review of significant events, complaints, safeguarding alerts and other issues related to clinical governance. The governance board held responsibility for closing incidents and complaints following investigation.
- We looked at the quarterly quality report for October 2016 to December 2016 and saw there was a clear drive to resolve clinical governance issues and review performance in the centre. For example, nine out of the 10 complaints received in the quarter had been resolved to the satisfaction of both parties and the team identified four out of five safeguarding referrals had been made to the appropriate team.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. This included for locum doctors who were included in clinical governance meetings to ensure they offered the same service as salaried GPs.
- A comprehensive understanding of the performance of the practice was maintained by the leadership team.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Staff demonstrated understanding of the duty of candour and could demonstrate how it was used in practice. For example when a patient was administered a double dose of paracetamol staff apologised to the patient, explained the situation and implemented an investigation.

There was evidence the senior leadership team identified areas for improvement in governance and quality assurance and acted on this. For example, in February 2016 the team highlighted the need for a 'director's dashboard', which they could use to track performance, identify trends in patient access to the centre and establish benchmarks for staffing levels. This had been implemented and the dashboard formed the basis of future staff meetings, which enabled staff to identify areas of good performance and what needed to be improved.

In March 2017 the senior team identified a need for more frequent and structured clinical governance processes and planned to introduce weekly protected time for GPs and nurse prescribers to meet to discuss learning from cases, continuing professional development, significant events and safeguarding. This weekly time would also be used to ensure the clinical team were up to date with changes to National Institute of Health and Care Excellence guidance.

**Leadership and culture**

A clinical director, a director of operations, centre manager and a director of governance led the service, supported by a general manager and a matron.

On the day of our inspection the centre team demonstrated they had the experience, capacity and capability to run the centre to meet demand and ensure high quality care. There was a track record of prioritising safe, high quality and compassionate care within a culture of 'no blame'. This meant staff were supported to learn from mistakes without fear of reprisal. All of the staff we spoke with told us the matron and senior team were approachable. One nurse said they felt there was no hierarchy in the centre, which contributed to a positive working environment.

Meetings between GPs and nurses took place quarterly as part of a culture of learning from shared experiences.

# Are services well-led?

Good

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

The practice had an ethos of promoting staff development and investing in training and staff told us this made them feel valued. For example, a nurse practitioner was undertaking specialist urgent care paediatric training as part of their continuing professional development.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents.

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

- Risk-based meetings were scheduled as needed to address specific issues or concerns. For example, the senior team scheduled a meeting in January 2017 to discuss an update to triage and escalation processes.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days took place twice annually.

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

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

- The centre matron gathered feedback from staff and acted on this. For example, urgent care technicians (UCTs) requested their working hours be changed slightly to start earlier so that they had time to prepare clinical areas before the centre opened. The matron identified a clear rationale for this presented by the UCTs and presented the case to the organisation's directors for approval.
- The senior team acted on feedback from the patient survey, such as by improving communication during times of high levels of demand.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment, 2(1): Care and treatment must be provided in a safe way for service users.<br><br>**How the regulation was not being met:**<br><br>The registered provider did not have consistent, safe processes in place ensure learning from incident investigations and updates from the Medicines and Healthcare Products Regulatory Agency was implemented by all appropriate staff.<br><br>The centre must ensure there is a system in place to ensure all staff are made aware of learning from significant events and the senior team are assured changes to practice are implemented.<br><br>The provider must ensure there is an effective system in place to ensure all staff are aware of updates to practice as a result of national patient safety alerts and alerts from the Medicines and Healthcare Products Regulatory Agency.<br><br>This was in breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |