County Durham and Darlington NHS Foundation Trust

RXP

Urgent care services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXPBA	Bishop Auckland Hospital		
RXPRD	Seaham Primary Care Centre		
RXP11	Shotley Bridge Community Hospital		
RXP09	Peterlee Community Hospital		

This report describes our judgement of the quality of care provided within this core service by County Durham and Darlington NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by County Durham and Darlington NHS Foundation Trust and these are brought together to inform our overall judgement of County Durham and Darlington NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated this service as good, although safety was rated as requires improvement. Although staff told us that there were usually sufficient staff to meet the need of the patients, there were high levels of staff sickness at the urgent care centre at Peterlee Community Hospital. Long-term sickness was being managed and agency staff were occasionally used to cover at Peterlee, with cover at other sites being provided by staff working longer hours or staff from other centres covering vacant shifts. Several staff from Bishop Auckland urgent care centre had recently left the service due to the uncertain future of the service. Staff teams usually consisted of GPs, urgent care practitioners and healthcare assistants. Staffing levels in centres were much higher during the day than at night and often, at Shotley Bridge urgent care centre, a single member of staff could be left to work in the department if a GP was called away. In one centre, the urgent care practitioner also held the second crash pager for the whole community hospital, to support the Advanced Nurse Practitioner within the hospital. Incidents of violence and aggression towards staff had been reported by staff and a security alert had been raised at Peterlee urgent care centre when a member of staff had felt threatened at night. A risk assessment had subsequently been carried out.

Staff were confident in reporting incidents and safeguarding concerns and we saw from staff meeting minutes that incidents and learning from incidents were discussed regularly. There was a child protection lead practitioner in the team. Documentation was correctly and consistently completed. Staff knew the procedure to follow if a patient's condition deteriorated and transfer to the emergency department or admission to the acute site was required.

We saw some evidence of assessment tools in use. There was audit undertaken to monitor quality and people's outcomes Multidisciplinary team meetings were held quarterly in each centre and included a range of staff (e.g. GP/Reception/Practitioner/HCA). Cross Centre Clinical Governance meetings were held monthly. Across all centres there were good relationships with local GP practices. Information was available via the electronic records system and discharge information was available electronically to other users of the system, such as local GPs.

Staff were competent in their roles and attended regular quarterly team meetings. They discussed best practice and changes in guidelines. Staff competency documents and supervision notes were unavailable during our visit. There were a number of care pathways in use, which demonstrated good patient outcomes. Staff told us that trust guidelines and National Institute for Health and Care Excellence (NICE) guidance were followed across all centres. They also explained that they frequently used their own clinical judgement and relied on professional integrity and responsibility.

Patients and their relatives or carers were treated in all interactions with dignity, respect and care was provided in a compassionate way. They were provided with relevant verbal information, emotional support and explanations about their care and staff checked patients' understanding of the care planned and provided.

Radiology was available during the day at Shotley Bridge, Bishop Auckland and Peterlee centres. Patients attending Seaham urgent care centre would need to be transferred to Peterlee urgent care centre for radiology services. Premises were accessible for patients with limited mobility and peoples' individual needs were well met by the delivery of patient-centred care. All services worked well together and coordinated within and across sites to ensure the best possible care was given. There was good access for staff to refer to the mental health team, who would attend the unit if called. There were clear criteria for ensuring all babies and pregnant women were seen by a GP, as well as patients returning to the centre on two or more occasions.

Governance structures were clear to both staff and managers. Learning from incidents was shared via the urgent care clinical governance group, which also discussed peer support and reviews. The management and leadership of urgent care had changed and a relatively new postholder was managing services across the stand-alone urgent care centres (Bishop Auckland, Shotley Bridge, Peterlee and Seaham). The culture within

Summary of findings

the service was mostly positive and confident and was actively looking at ways to improve. All the staff we spoke with were positive about the contribution they made to patient care and were very positive about the teams they worked in. Staff felt supported by managers, despite experiencing a prolonged period of transition and change, and reported effective team working. The changes were aimed at improving the services for local communities and ensuring sustainability.

Summary of findings

Background to the service

There were six Urgent Care Centres in the Trust. Facilities were provided at three of the community hospitals. (Shotley Bridge, Peterlee and Bishop Auckland), two of primary care centres (Seaham, Dr Piper House) and one acute hospitals (University Hospital of North Durham). At 6pm Dr Piper House closed and the service operated from the A&E department at Darlington Memorial Hospital. Patients could access a GP by attending the centres, calling 111 to make an appointment or requesting a telephone conversation or a home visit, except at Seaham, which was a practitioner-led service operating from 8:00 am to 6:00 pm. 999 services were not directed to these locations.

At Bishop Auckland Hospital, there was an urgent care centre that opened 24 hours a day, 365 days per year and it provided immediate care for minor injuries and ailments. There was an x-ray department on site, within the community hospital which provided CT scanning and x-rays from 9am to 9pm on weekdays and 9am to 5pm at weekends. There were approximately 1,200 patient attendances per week, about one third of which were 111 referrals and the other two thirds were 'walk-ins'. The total number of attendances for the previous 10 months was 111,719.

At Seaham Primary Care Centre, there was an urgent care centre which operated as a satellite site to Peterlee Community Hospital urgent care centre. The centre was open from 8am to 6pm every day. The total number of attendances for the previous 10 months was 19,000.

At Peterlee Community Hospital there was an urgent care centre which operated 24 hours a day, 365 days per year, providing immediate care for minor injuries and illnesses. There was an x-ray department on site, within the community hospital that provided ultrasound and x-ray services from 8:00 am to 8:00 pm on weekdays and 10:00 am to 3:00 pm at weekends. Medical cover was provided by GPs. The building and other departments on the site belonged to North Tees and Hartlepool Hospitals NHS Foundation Trust. 10% of attendances were prebooked by the 111 service and the remaining 90% were people walking in for care. The total number of attendances for the previous 10 months was 94,000.

At Shotley Bridge Community Hospital there was an urgent care centre which had recently undergone a review and patient consultation, with a view to reducing the service to a minor injuries unit, although it remained an urgent care centre at the time of the inspection. The centre was practitioner-led and open Monday to Friday from 8:00 am to 12 midnight; GPs were available from 6:00 pm to 8:00 am weekdays and 24/7 at weekends. The total number of attendances for the previous 10 months was 63,000.

Our inspection team

Our inspection team was led by:

Chair: Iqbal Singh, Consultant Physician in Medicine for Older People.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: doctors, nurses, therapists, a health visitor, district nurses, community matrons, a GP and experts by experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 3 to 6 February 2015.

We held listening events on 26 January and 2 February 2015 in Darlington and Durham to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

What people who use the provider say

All patients and relatives we spoke with were positive about the service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider should take to improve

- Review staffing at night within the urgent care centres.
- Review need for paediatric trained nurses in the urgent care centres.
- Improve audit activity to monitor quality and patient outcomes.

County Durham and Darlington NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Although staff told us that there were usually sufficient staff to meet the need of the patients, there were high levels of staff sickness at Peterlee Community Hospital. Long-term sickness at this site was being managed and because the usual process is for staff to work longer hours or staff from other centres cover vacant shifts, there was only the occasional use of agency staff to cover sessions. Several staff from Bishop Auckland urgent care centre had recently left the service due to the uncertain future of the service. Staff teams usually consisted of GPs, urgent care practitioners and healthcare assistants. Staffing levels in centres were much higher during the day than at night and often a single member of staff could be left to work in the department if a GP was called away. In one centre, the urgent care practitioner also held the second crash pager for the whole community hospital, to support the Advanced Nurse Practitioner within the hospital. Incidents of violence and aggression towards staff had been reported by staff and a security alert had been raised at Peterlee urgent care centre when a member of staff had felt threatened at night.

Staff were confident in reporting incidents and safeguarding concerns and we saw from staff meeting minutes that incidents and learning from incidents were discussed regularly. There was a child protection lead practitioner in the team. Documentation was correctly and consistently completed. Staff knew the procedure to follow if a patient's condition deteriorated and transfer to the emergency department or admission to the acute site was required.

The most recent formal infection control audit information we could find was from October 2013. However, cleaning schedules were in place and signatures were fully accounted and up to date, and we saw no breaches in cleanliness or infection prevention and control protocols.

Detailed findings

Incident reporting, learning and improvement

- Staff reported incidents using the trust electronic reporting system .All members of staff had access to the system and were aware of how to use it, felt able to report incidents and raise concerns in a 'no blame' culture.

Requires improvement

Are services safe?

- We saw that when an incident occurred, a full analysis of the issues was recorded, actions planned to prevent similar incidents and consideration of reporting through the Strategic Executive Information System (STEIS) and National Reporting and Learning System (NRLS).
- An average of 20 incidents were reported per week.
- Staff we spoke to were confident in how to report serious incidents and they told us there was an open 'no blame' culture when reporting incidents. We saw from staff meeting minutes that incidents and learning were discussed regularly and staff were encouraged to engage with the process.
- One serious incident had led to learning across all centres and changes to the patient pathway.
- Some staff were aware of Never Events (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented), but this was not consistent across the services.
- There were no Never Events reported by the Urgent Care Centres in the 12 months prior to the inspection.
- There were an average of two or three incidents of violence and aggression per month at Peterlee Community Hospital urgent care centre and staff had raised the issue of security when the manager first came into post.
- Staff had raised a security alert the week before our visit when a member of staff had felt threatened at night. We discussed the use of a lone-working policy and the manager discussed the opportunity to initiate this at the site. There had been no security risk assessment, but it would be considered for the future.

Duty of Candour

- All staff were aware of the principles of Duty of Candour and the need for an open, honest and transparent culture.
- Compliments and complaints were displayed on noticeboards in waiting areas.

Safeguarding

- Staff training showed that most staff had completed training for safeguarding adults and children to Level 3. However, some staff at Seaham Primary Care Centre were still to complete their courses. Matron showed us confirmed booking information for all outstanding staff training which would take place before the end of March 2015.
- Staff we spoke with were confident in reporting safeguarding concerns and were aware of how to escalate concerns to a designated member of the safeguarding team. They gave a recent example of a referral to the local authority safeguarding children's team.
- Systems were in place on the electronic record to identify patients identified at risk and those who had repeated attendances at the urgent care centres. Staff demonstrated how they could backtrack on records if they suspected non-accidental injuries, outlined the child protection alert system and reporting mechanisms. There was a Child Protection lead practitioner in the team.

Medicines management

- Medicines were stored tidily, safely and securely.
- Prescriptions were computerised.
- Some urgent care practitioners were prescribers.
- Patient group directives (PGDs) were in place and up to date. The lead pharmacist had overall responsibility for PGDs and provided support, reviews and checks.
- Paramedic urgent care practitioners and advanced nurse practitioners worked to the trust's 60 patient group directives (PGD). It was recorded on the electronic record whether the patient met the inclusion and exclusion criteria.

Bishop Auckland Hospital

- At Bishop Auckland Hospital common medicines were kept in stock. Others were prescribed and could be dispensed by local pharmacies, one of which was a large supermarket with extended opening times. Staff tended to prescribe most medicines during the day and, therefore, conserve stocks for night time.

Peterlee Community Hospital

- The medicines management adviser carried out spot checks and planned visits for controlled drugs checks, discrepancies and troubleshooting.

Seaham Primary Care Centre

- At Seaham Primary Care Centre, the drug cupboard was locked, clean and tidy. The practitioner had identified some drugs due to expire at the end of the month and Pharmacy had been made aware.
- At Seaham Primary Care Centre, ENTONOX® and oxygen cylinders were stored in identified rooms and in trolleys.

Requires improvement

Are services safe?

- At Seaham Primary Care Centre, the drug fridge had not been checked on a regular basis; a few checks in November and 17 days omitted in December. There was no feeling that anyone in particular was responsible for this. Staff knew temperatures should be recorded but only had time to do this on some days.

Shotley Bridge Community Hospital

- The trust medicines management lead visits the centre when required and advises when drugs go out of use.
- A full drugs (including controlled drugs) check was carried out every morning.

Safety of equipment

- Resuscitation equipment, defibrillators and drugs were available and checked daily.
- We saw that most equipment that required regular servicing or calibration was maintained in line with trust and manufacturers' guidelines. However scales at Peterlee Community Hospital urgent care centre showed no evidence of having been calibrated.
- An oximeter at Peterlee Community Hospital urgent care centre had last been checked in 2009. This was taken out of use by the urgent care practitioner during our visit.
- Electrical equipment was subject to Electrical Safety Testing (EST) annually.
- PAT slides, wheelchairs and a bariatric wheelchair were available, clean and in good condition.
- Beds in the consulting rooms at Peterlee Community Hospital urgent care centre had no side rails so a practitioner working alone would not be able to leave a patient if they needed to call for assistance. Staff told us that they would have to use a panic alarm to get help.

Records and management

- An electronic record system was in use across all urgent care centres. This had a flagging system for patients considered at risk. Full GP notes were also available and if the GP was not using the system then a summary was available.
- Contemporaneous records were made during consultation and following attendance by a patient.
- Staff completed electronic records using SystmOne. We observed 12 records and all were complete on the system and the records could be accessed by all health professionals involved in the patients care.
- Documentation was correctly and consistently completed.
- A documentation audit was carried out, looking at 5 sets of practitioners' notes and clinical assessments. A template had been created and team leaders passed on the results to the matron.
- X-ray reports were undergoing audit to check how many investigations we ordered and reasons for them as checking missed fractures. Staff told us that they could access urgent x-ray reporting if necessary when the x-ray department was open on site.

Cleanliness, infection control and hygiene

- The environments were visibly clean and all buildings were in good condition.
- We saw that staff followed the bare below the elbows trust policy and national guidelines, and that they washed their hands between patient contacts and alcohol gel was available for staff, patients and visitors at each location.
- Personal protective equipment (PPE) was readily available and we saw staff using items such as aprons and gloves appropriately and when required.
- In clinical areas we saw that the environment was clean and well maintained. There were adequate facilities for the safe storage and disposal of equipment and clinical waste.
- At Shotley Bridge, the most recent formal infection control audit information we could find was from October 2013. However, cleaning schedules were in place and signatures were fully accounted and up to date, and we saw no breeches in cleanliness or infection prevention and control protocols.
- Disposable curtains were used in cubicle areas at Shotley Bridge Community Hospital.
- Ebola FIT test and PPE training was incomplete since October 2014 because the member of staff responsible to ensure all staff had completed the test had left the service.

Mandatory training

- Mandatory training was managed centrally and training places were booked for them at appropriate intervals. We were told by staff and managers that the system worked well and ensured that all mandatory and role specific training was up to date.

Requires improvement

Are services safe?

- Mandatory training records that showed all staff had received training or were booked to complete it before the end of March 2015.
- All urgent care practitioners in the Peterlee Urgent Care Centre had undertaken Paediatric Safeguarding Level 3 and Paediatric Advanced Life Support (ALS) training, and all GPs employed through the Trust had undertaken Paediatric Safeguarding Level 3.
- All practitioners in the urgent care centres had undertaken intermediate life support (ILS) and basic life support (BLS) training.

Assessing and responding to patient risk

- An escalation policy was in place and staff gave examples of when they had requested emergency ambulance transfer to the nearest acute hospital.
- Algorithms for treatment of asthma, urinary tract infection were on display and others were available on the trust intranet.
- At Seaham Primary Care Centre, a GP was available for staff to speak to by telephone from Peterlee Community Hospital urgent care centre, or since most patients were registered with the GP practice that shares the building, they could request to see a GP there.
- Staff told us that if patients were frequent attenders then the service would send a letter to the GP.

Staffing levels and caseload

- Staff told us that there were usually sufficient staff to meet the need of the patients and staff worked well together to ensure that all patients were seen.
- Services provided staffing cover for each other at times of sickness or holidays. They would contact the on-call manager to request staff cover.
- An employee who was approaching retirement was on long-term sick leave. Sickness issues were being managed by the matron and cover was provided by staff working longer hours or staff from other centres covering vacant shifts, with some minimal use of agency staff.

Bishop Auckland Hospital

- Several urgent care practitioners had recently left the service due to the uncertain future of the service.
- There was a team of GPs, urgent care practitioners with either a nursing or paramedic background, healthcare assistants and reception staff.
- There were no qualified paediatric nurses, but many of the urgent care practitioners had undergone paediatric skills training. However, it was not clear whether there was always a member of the team with these competencies on duty at every shift.
- Trainee GPs were accommodated on placement and were given full local induction at the start of their first shift.
- Four to five urgent care practitioners were on duty each day with one healthcare assistant. The higher numbers were usually to cover busy weekend shifts.
- There were vacancies for healthcare assistants and staff told us that these staff were needed to support GPs who work as independent practitioners to enable them to see patients more quickly and efficiently.
- From 12 midnight the staffing quota consisted of one urgent care practitioner (UCP), one Healthcare Assistant, a Receptionist and a GP. The UCP held the second crash bleep to support the Advance Nurse Practitioner working in the hospital. The GP was also responsible for home visits.

Peterlee Community Hospital

- Medical cover was provided by agency GPs from Primecare, an agency providing GP locum cover. These GPs locums had worked with the urgent care centres previously and were part of the integrated teams.
- There had been more staff sickness recently, so agency staff were used more than previously. However, no agency staff worked alone at night. Staffing concerns had been added to the risk register.
- Staff told us that children were the highest proportion of patients cared for. However, there were no qualified specialist children's nurses of the staff team. Band 7 staff were all trained in paediatric physical assessment skills or had this training scheduled. GPs would see children and, in particular, babies under three months old.
- The receptionist carried out first contact protocol and, in common with receptionist at all centres, was basic life support (BLS) trained.

Seaham Primary Care Centre

- Seaham Urgent Care Centre was nurse-led. Staff worked on rotation from Peterlee Community Hospital. The service was staffed by two advanced emergency practitioners, one of whom, at the time of our visit was a paramedic; the second person was an advanced nurse practitioner.

Requires improvement

Are services safe?

- Staffing had been problematic, but the unit was always staffed with two urgent care practitioners.

Managing anticipated risks

- There were business continuity plans in place for all eventualities, such as loss of building or utilities. The continuity plans ensured that urgent and high risk patients could be identified and care maintained.
- We discussed the lone working policy and matron considered this might be a good policy to adapt for staff in urgent care centres. Risk assessments had been undertaken and some discussions had taken place. We were later advised that the Trust has a lone worker policy, which is a Trust-wide document covering all staff groups.
- Security systems were well planned and staff told us they felt safe at work, considering some sites were quiet at night. All doors had security locks and staff had quick access to personal and static panic alarms.
- The security manager provided support when incidents regarding security were reported on the Safeguard incident reporting system.
- There were no risk assessments in place in respect of: paediatric care and prescribing by non-paediatric trained nurses and practitioners; security for staff out-of-hours when the centre was the only service open in the building; or lone-working. There was a lack of staff acknowledgement that this absence of risk assessments was a matter for concern for staff, patients and the service.

Major incident awareness and training

- Staff were aware of the trust major incident policy and were aware of their role and responsibility if such an incident were declared.
- A flow chart displayed in a staff room demonstrated the process to be followed.

Good

Are services effective?

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

Summary

Staff told us that trust guidelines and National Institute for Health and Care Excellence (NICE) guidance were followed across all centres. They also explained that they frequently used their own clinical judgement and relied on professional integrity and responsibility. We saw some evidence of assessment tools in use. There was audit undertaken to monitor quality and people's outcomes.

Staff were competent in their roles. Staff competency documents and supervision notes were discussed, but staff were unable to access and demonstrate these for us during our visit.

There was a national difficulty in recruiting GPs, so, although most cover was provided by GPs employed by the Trust, where shifts could not be filled by Trust employees agency staff would be used. Across all centres there were good relationships with local GP practices.

Information was available via the electronic records system and discharge information was available electronically to other users of the system, such as local GPs.

Patients were asked for their verbal consent during consultations and prior to undertaking any intervention.

Staff had all received training in consent and displayed a good working knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Detailed findings

Evidence-based care and treatment

- We saw that care provided was in keeping with trust and service-specific policies and procedures.
- A number of care pathways were embedded in practice, including Sepsis Six, knee pathway, ear, nose and throat (ENT) and fractured nose, ophthalmology (eye injury), myocardial infarction (MI). With chest pain, two pathways were used: 'current chest pain' and 'chest pain now settled'.
- Staff explained that they frequently used their own clinical judgement and relied on professional integrity and responsibility.
- Staff told us that trust guidelines were followed across all centres.
- Staff were able to show how NICE guidance on the care of feverish children had been implemented in recent months.

Pain relief

- Patients were assessed for pain and provided with pain relief in accordance with a prescription or patient group directives.

Outcomes of care and treatment

- The Urgent Care Centres used the WELLs score, DVT assessment tool, Sepsis screening tool, a Knee assessment pathway and Asthma pathway to monitor patient outcomes..

Competent staff

- All the staff we spoke to told us that they had received regular appraisals that were linked to individual training and development plans. Information that we received confirmed that most staff had received appraisals. The matron assessed appraisals and sent acknowledgement to managers and staff.
- Staff attended regular quarterly team meetings to discuss problems within departments and any reported incidents. They also discussed best practice and changes in guidelines. We saw minutes of the last meeting at our visit.
- GPs had 10% of their salaried hours set aside for protected learning time and medical staffing was increased to backfill for this.
- The trust used agency GPs most weeks. Where possible, agency GPs who knew the service and had completed an appropriate induction covered the shifts.
- The matron asked GPs for evidence of their appraisals and ensured that the agency sent evidence of GMC updates and correct framework information.
- Nursing and paramedic students were offered placements within the service.
- Responsibilities for link practitioners were shared across the teams.

Good

Are services effective?

- The matron discussed a staff competency document and competency tool, but was unable to access and demonstrate these for us during our visit.
- Urgent care practitioners were bands 6 and 7 with background in nursing or paramedic qualification.

Peterlee Community Hospital

- Staffing at night consisted of one receptionist, one emergency care practitioner (ECP) and one GP. If the GP was called out on a home visit the ECP would be left to work alone, although the receptionist would remain on site. The GP driver would report back when the GP was available.
- We found no evidence that collective paediatric competencies had been signed off.
- We were told that nurse prescribers used trust formulary drugs for paediatric prescriptions. National guidance states that, in order to prescribe paediatric drugs, the prescriber should have passed "physical assessment of the child".
- We were told that staff supervision notes were held electronically at this site, but staff were unable to access them at our visit.

Seaham Primary Care Centre

- An advanced care practitioner was currently undertaking a master's degree in managing under-fives with feverish illness and linking this to current NICE guidelines.

Shotley Bridge Community Hospital

- In common with all of the urgent care centres, Advanced Nurse Practitioners took lead roles in infection prevention and control, pharmacy, resuscitation.
- The department was well staffed with six advanced nurse practitioners and four nurse practitioners.
- GP cover was in place after 6pm and at weekends. There was difficulty recruiting GPs, so most cover was provided by locum and agency GPs.

Multidisciplinary working and coordination of care pathways

- Staff at Peterlee Community Hospital urgent care centre reported good links with local police. The police station was next door and frequent patrols checked on the centre, especially at night and weekends.
- Patients had direct access to fracture treatment and clinics.
- At Shotley Bridge Community Hospital team meetings of all multidisciplinary staff working in the department were held quarterly.
- There were good relationships with local GP practices and staff would liaise with GPs if a patient needed a referral to secondary care.
- All urgent care centres used the same treatment pathways and algorithms.
- Staff only took blood samples for the deep vein thrombosis (DVT) pathway.

Referral, transfer, discharge and transition

- Patients were admitted to University Hospital of North Durham or Darlington Memorial Hospital if their condition met the trust's escalation criteria.

Availability of information

- Information was available via the electronic records system (SystemOne). Staff support was given on induction in understanding and using the record system.
- Discharge information was available electronically to other users of the system, such as local GPs.
- Paper records were kept of frequent child attenders and vulnerable adults.

Consent

- We observed patients being asked for their verbal consent during consultations and prior to undertaking any intervention.
- Staff had all received training in consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards as part of trust core essential training.
- Staff had a good working knowledge of the Mental Capacity Act 2005 and knew how to raise concerns about the deprivation of liberty for individuals.
- Not all staff questioned were able to explain or give an example of a 'best interest' decision.
- At Shotley Bridge Community Hospital, Gillick competencies and Fraser guidelines were used, but there was no clear departmental approach in place.

Good

Are services caring?

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

Summary

Patients and their relatives or carers were treated in all interactions with dignity and respect and care was provided in a compassionate way. Patients and relatives all spoke positively about the service.

Patients were provided with relevant verbal information, emotional support and explanations about their care and staff checked patients' understanding of the care planned and provided.

Health promotion information and a range of patient information leaflets was available in reception and waiting areas.

Detailed findings

Dignity, respect and compassionate care

- We saw that patients and their relatives or carers were treated in all interactions with dignity and respect and we observed care being provided in a compassionate way.
- Patients were treated in single rooms for privacy and dignity.
- We spoke with 12 patients and relatives, who all spoke positively about the service.

Patient understanding and involvement

- Patients were provided with relevant verbal information and explanations about their care.
- Staff checked patients' understanding of the care planned and provided.
- Most patients were seen in a timely fashion and at the time of our visit patients were advised that the anticipated waiting time was one hour.

Emotional support

- Staff told us that part of their job was to provide emotional support to patients, their carers and families.
- Patients were provided with appropriate emotional support during consultations.
- Staff were aware of contact information for referral of patients to the local mental health team, if required.

Promotion of self-care

- There was health promotion information displayed throughout the centres.
- A range of patient information leaflets was available in reception and waiting areas.

Good

Are services responsive to people's needs?

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

Summary

The centres covered a population in a wide geographical setting with many distinct communities. Services were organised and planned around the natural communities and higher populations.

Most urgent centres across the trust met the 4 hour wait target. There were a number of care pathways in use, which demonstrated good patient outcomes.

Community services contracts were due to be re-tendered in 2015 and although staff were being kept informed by managers on a weekly basis, this was a period of uncertainty and staff felt they had little influence over the process.

Evenings and weekends were the busiest periods and staffing was tailored to meet demand. Staff reported few drug or alcohol related incidents, but panic alarms were readily available for staff to use. Police response was good when requested although distances from support varied across locations. Radiography was available during the day at all centres apart from Seaham.

Premises were accessible for patients with limited mobility. Peoples' individual needs were well met by the delivery of patient-centred care. All services worked well together and coordinated within and across sites to ensure the best possible care was given.

There was good access for staff to refer to the mental health team who would attend the unit if called. There were clear criteria for ensuring all babies and pregnant women were seen by a GP, as well as patients returning to the centre on two or more occasions. Staff knew the procedure to follow if a patient's condition deteriorated and transfer to the emergency department, or admission to the acute site was required.

All staff we spoke to told us they tried to deal with complaints immediately and would always say sorry to the complainant. As a result of early stage resolutions the number of formal complaints were few.

Detailed findings

Planning and delivering services which meet people's needs

- County Durham and Darlington NHS Foundation Trust cover a population in a wide geographical setting with many distinct communities. Services were organised and planned around the natural communities and services were situated in areas of high population.
- There were a number of care pathways in use, such as Sepsis Six, DVT, stroke, acute chest pain, headaches, knee injury and head injury pathways, which demonstrated good patient outcomes.
- We were told by staff that community contracts would be re-tendered in 2015. Although staff were being kept informed by managers on a weekly basis, this was a period of uncertainty and staff felt they had little influence over the process.
- There was information displayed regarding who was suitable to be seen at urgent care centres displayed on site and on the trust's internet site.
- Managers monitored attendance across the urgent care centres.
- Radiology was available during the day as follows: at Bishop Auckland Hospital on weekdays from 9am to 9pm and at weekends from 9am to 5pm; at Peterlee on weekdays from 8am to 8pm and at weekends from 10am to 3pm; and at Shotley Bridge from 9am to 4:45pm every day. Patients at Seaham centre would be transferred to Peterlee to access radiology services.
- Evenings and weekends were the busiest periods and staffing was tailored to meet demand. Staff reported few drug or alcohol-related incidents, but panic alarms were readily available for staff to use. Police response was good when requested.
- Almost all local GPs used the same electronic record system (SystmOne), so previous history of patients was evident and staff were able to obtain a good picture of patients' needs.

Seaham Primary Care Centre

- The waiting area was small and not visible from the reception desk. The receptionist told us that they would alert staff if there were any problems in the area.

Equality and diversity

Good

Are services responsive to people's needs?

- Premises were accessible for patients with limited mobility.
- There was access to interpreter services if required. However, patients often brought a relative who could speak English or, more increasingly, accessed interpreter services on their phone.
- Staff displayed a clear understanding of treating each patient as an individual.
- Peoples' individual needs were well met by the delivery of patient-centred care. All services worked well together and coordinated within and across sites to ensure the best possible care was given.

Meeting the needs of people in vulnerable circumstances

- Patients with complex needs or mental capacity issues were transferred to the appropriate service.
- There was good access for staff to refer to the mental health team who would attend the unit if called.
- A (symptoms of anxiety and depression) SAD score system had been introduced for all patients identified as having depression or anxiety symptoms, or those expressing suicidal thoughts. This had been implemented following a serious incident and lessons learned.

Access to the right care at the right time

- Most urgent centres across the trust met the 4 hour wait target.
- When waiting time targets were breached, they were reported appropriately.
- There were clear criteria for ensuring all babies under 20 weeks and pregnant women were seen by the GP. Any patient seen by an urgent care practitioner twice for the same condition would be seen by the GP if they returned again.
- Staff knew the procedure to follow if a patient's condition deteriorated and transfer to the emergency department or admission to the acute site was required.

Bishop Auckland Hospital

- Staff reported that waiting times up to and over the Christmas period had been poor due to an increase in the number of attendances.

Seaham Primary Care Centre

- Patients were usually seen within 30 minutes of booking in with a maximum recorded wait of two hours.
- We were told that, occasionally, the information relayed via the 111 service was incorrect and ambulances could be delayed, which meant that patient safety may have been at risk.

Complaints handling (for this service) and learning from feedback

- Staff we spoke to were aware of the local complaints procedure and were confident of dealing with complaints as they arose. All staff we spoke to told us they tried to deal with complaints immediately and would always say sorry to the complainant. As a result of early stage resolutions the number of formal complaints were few.
- One complaint, that patients in a waiting area could hear conversations from the staff room, resulted in staff no longer holding confidential discussions in that room.
- A total of about four or five complaints were made each month across all the services.
- Minutes from staff meetings showed that issues from patient concerns and complaints were discussed regularly and practice altered to ensure a repeat of issues identified. We were told that the majority of these that were investigated were unfounded. For example, patients had complained of not being prescribed antibiotics for a sore throat. But where a genuine error had occurred, such as a missed fracture then an apology and an explanation would be offered.
- Staff had attended conflict resolution training.

Good

Are services well-led?

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

Summary

Governance structures were clear to both staff and managers. Learning from incidents was shared via the urgent care clinical governance group, which also discussed peer support, reviews and lessons learned. Performance was measured. However, quality measurement regarding the urgent care centres and audit was limited.

The management and leadership of urgent care had changed and a new post was designed to manage the services across all the trust's urgent care centres. We learned that there had been several people in this post in recent years. There were considerable expectations by the trust for this role and the capacity to undertake the full role and deliver a safe service.

The culture within the service was mostly positive and confident. The service was open and transparent in reporting incidents and was actively looking at ways to improve. All the staff we spoke with were positive of the contribution they made to patient care and were very positive about the teams they worked in.

Staff felt supported by managers, despite experiencing a prolonged period of transition and change, and reported effective team working.

Detailed findings

Service vision and strategy

- The trust vision and strategy of 'Right first time, every time' was well understood by all staff that we spoke to.
- Everyone could relate the vision to their own service area and believed that, on the whole, this was achieved.
- One member of staff felt that the trust did not understand the urgent care centres' philosophy.
- The services were going through a period of change and work was in progress with commissioners to clarify the services to be provided. However, staff felt unsettled, and initially excluded, and there had been a number of highly skilled urgent care practitioners who had recently left the service.
- Staff told us that one aim for the future was to rotate qualified staff around the urgent care centres to share best practice and experience. However, they believed that during the transition would not be the best time to introduce the topic.

Bishop Auckland Hospital

- Staff believed that the service was rare and one of a kind, with 24-hour GP cover, seven days a week and that by looking after non-urgent injuries and illnesses their service had a positive effect on inappropriate emergency department attendances and provided local patients with somewhere else to go.

Governance, risk management and quality measurement

- Governance structures were clear to both staff and managers.
- Learning from incidents was shared via the urgent care clinical governance group, which was chaired by a GP, with matrons and practitioners from each centre in attendance. This group also discussed peer support and reviews and a 'lessons learned' bulletin was sent to all staff via email. Key messages were displayed on staff noticeboards.
- Staff felt included and communication was good. There was an opportunity to articulate their concerns.
- Performance was measured. However, quality measurement regarding the urgent care centres and audit was limited.
- Clinical governance meetings looked at care pathways and information and decisions were disseminated to staff through the matrons and team leads.
- Staff had access to panic alarms and the police station was nearby, but security and safety for staff at night had not been considered.

Leadership of this service

- The matron was responsible for line management of urgent care practitioners, GPs and custody service staff.

Good

Are services well-led?

- The management and leadership of urgent care had changed and a new matron had been in post for only a few months to manage the services across all the trust's urgent care centres.
- Staff felt that matron was effective and responsive and had been helping with integration of the service.
- We learned that there had been five different people in the matron's post in the six years prior to the inspection and there were considerable expectations by the trust for this role and the capacity to undertake the full role and deliver a safe service.
- The restructuring and changes to the leadership of the service had not been welcomed by all staff and several had left the service. It was not clear whether this was because of future uncertainty or the change in leadership. Previously, there had been a unit manager at each service and this had been amalgamated into one post to cover all four units.
- Staff told us that the head of the service was very supportive, but busy too.
- Staff meetings and team lead meetings took place monthly and minutes were shared with all staff via email and displayed on staff noticeboards.
- Staff told us that the clinical team leads were always available by email.

Culture within this service

- Staff felt that leaders were accessible and understood the needs of the patients.
- The culture within the service was mostly positive and confident. Staff told us it was an open culture and that they were encouraged to report concerns or incidents on the basis of 'no blame'. The service was open and transparent in reporting incidents and was actively looking at ways to improve.
- All the staff we spoke with were positive of the contribution they made to patient care and were very positive of the teams they worked in.
- Staff felt supported by managers, despite experiencing a prolonged period of transition and change, and reported effective team working.

Fit and proper person requirement

- Staff understood the requirement to check that all staff were fit for their role and had been briefed about the new legislation regarding board members and directors.

Public and staff engagement

- Staff felt involved and that information was shared. A monthly staff bulletin was sent by email to all staff and was displayed on staff noticeboards.
- We were told by managers that, on a yearly basis, executive and non-executive directors were transported around the county meeting staff and service users to get feedback and engage with frontline staff.

Innovation, improvement and sustainability

- The urgent care centres were going through a period of transition and change. The changes were aimed at improving the services for local communities and ensuring sustainability.
- There was a plan for all new staff to complete competencies and they could access a clinical skills course through Teesside University. On completion of the adults course, they could then go on to the paediatric clinical skills course. They would be provided with a mentor in each unit to assess their clinical competencies.