Preston Integrated Urgent Care Centre

Quality Report

Royal Preston Hospital
Sharoe Green Lane
Fullwood
Preston
PR2 9HT
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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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Preston Integrated Urgent Care Centre on 12 October 2017. Overall the service 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 a system in place for reporting and recording significant events. The service took every opportunity to identify areas for improvement.
- The service had clearly defined and embedded systems to minimise risks to patient safety. Risk assessment was integral to service delivery.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. Staff training and development was well-supported by management.
- Patients' levels of satisfaction with the service were relatively high and the service used patient complaints and compliments to inform service developments.
- Information about services and how to complain was available. Staff were encouraged to reflect on their practice in relation to complaints.
- The provider was proactive in seeking patient and staff feedback and used surveys and "listening days" to learn how services could be improved. The patient journey was central to shaping services.
- The service had good facilities, although limited in space, and was well equipped to treat patients and meet their needs. A premises re-development was planned starting November 2017.
- There was a clear leadership structure and staff felt supported by management. Governance systems and processes were embedded and shared with other providers where appropriate. Service development was planned together with other services and tailored to the local health economy.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the service complied with these requirements.
- The leadership drove continuous improvement and staff were accountable for delivering change.

We saw two areas of outstanding practice:

Summary of findings

- Patients' individual needs and preferences were central to the planning and delivery of the service. For example, the service had worked with deaf expert patients to help understand the needs of those patients following a patient complaint. They designed their own patient leaflets to explain the services that they offered and to give patients health information.
- The service offered all staff a chance every year to bid for innovations that would benefit the organisation or the local community. We saw evidence of where this fund had been invested over the three years previously.

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 service is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the service. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The service had clearly defined and embedded systems, processes and practices to minimise risks to patient safety. Risk assessment was central to service planning.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the service minimised risks to patient safety.
- The service had effective systems in place to ensure patients were safe if they could not be seen immediately by a clinician.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The service had comprehensive arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The service is rated as good for providing effective services.

- Staff were aware of current evidence based guidance. The service used clinical audit and peer discussion to ensure that guidelines were followed.
- The provider met many of the service quality indicators. Where indicators were not being met, the service worked to address these.
- Staff identified patients who were contacting them frequently. The patient engagement manager telephoned them proactively twice a week to discuss their needs and offer support. We saw evidence that this successfully reduced contacts with the service.
- Both clinical and non-clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff. There was a strong emphasis on staff training and development.
- The service communicated efficiently with GP practices and other services to ensure patient care and treatment was safe and effective
- End of life care was coordinated with other services involved. The service used information provided by GPs and other services to provide effective care.

Are services caring?

Good

The service is rated as good for providing caring services.

- CQC patient comment cards showed that patients rated the service highly. Patients said they were treated with compassion, dignity and respect and they were reassured and put at ease by staff.
- There was a separate waiting area for children.
- Information for patients about the services available was accessible. The organisation had reviewed its policies and procedures to ensure that they supported people with characteristics protected by the Equality Act 2010.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- The service reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified.
- Staff from the service integrated with other healthcare providers to develop partnership care planning for patients across the local health economy.
- The service offered patients fully integrated urgent care during GP practice opening hours and out-of-hours care when practices were closed. They also offered patients an alternative to hospital admission service and a deep vein thrombosis (DVT) assessment, diagnosis and treatment facility.
- The premises were well-equipped with suitable facilities for patients. A redevelopment of these premises was planned in November 2017.
- Information about how to complain was available and evidence from examples we reviewed showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Outstanding 

The service is rated as outstanding for being well-led.

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The service business plan and strategy put patients at the centre of service development.
- There was a clear leadership structure and staff felt supported by management. There was a checklist for staff as to who to contact for any issue and we saw that staff with leadership roles were both visible and approachable.
- The service had policies and procedures to govern activity and held regular governance meetings. Additional governance meetings were held with other service providers and stakeholders.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. Joint governance meetings were also held with other service providers.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. The provider put a high value on staff development and training and staff told us that they were very supported with training.
- The provider was aware of the requirements of the duty of candour. In the examples we reviewed we saw evidence the service complied with these requirements. All staff were encouraged to reflect and learn from any incidents or complaints received.
- The organisation leadership encouraged a culture of openness and honesty. The service had systems for being aware of notifiable safety incidents and sharing the information with staff, and ensuring appropriate action was taken. Quality improvements resulting from incidents were implemented and monitored.
- The service proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The provider engaged with staff and patients through surveys and “listening days”.
- There was a high level of staff satisfaction. Staff told us they were proud to work for the service and felt engaged and supported in service development.

Summary of findings

- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas. All staff including locum staff were paid for any time that they spent attending service meetings.
- The service was proactive in identifying opportunities for development. There was an innovation fund offered annually for staff to propose business developments and new initiatives and we saw where these innovations had been introduced.
- The organisation offered a unique service which integrated both urgent care and out-of-hours services as well as an alternative to transfer service and a deep vein thrombosis pathway service.
- The provider was proactive in using technology to support the service delivery.
- The service hosted two physician associates each year through an agreement with Health Education North West.

Summary of findings

What people who use the service say

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 27 comment cards, two of which concerned the hospital emergency department service. All of the remaining 25 cards were positive about the standard of care received. Patients commented upon the helpfulness and friendliness of staff and of the high quality of the service. Several cards described the services offered by the provider as excellent and reassuring. Three of the cards also said that the waiting time in the service could be long although eight cards commented that the service was timely and efficient.

The service used the national Friends and Family Test (FFT) to gauge patient satisfaction. We saw that results for September 2017 showed that of the 42 responses, 33 people said that they were extremely likely or likely to recommend the service to family and friends (79%).

The service also conducted its own patient survey. We saw evidence that in the months of April to September 2017, 85% (35 of the total of 42) respondents were happy with the care they received, 12% (5) respondents stated they were partially happy and 5% (2) stated they were unhappy.

Outstanding practice

- Patients' individual needs and preferences were central to the planning and delivery of the service. For example, the service had worked with deaf expert patients to help understand the needs of those patients following a patient complaint. They designed their own patient leaflets to explain the services that they offered and to give patients health information.
- The service offered all staff a chance every year to bid for innovations that would benefit the organisation or the local community. We saw evidence of where this fund had been invested over the three years previously.

Preston Integrated 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 included a GP specialist adviser and an Inspection Manager.

Background to Preston Integrated Urgent Care Centre

Preston Integrated Urgent Care Centre (PIUCC) is located in the Royal Preston Hospital at Sharoe Green Lane, Fullwood, Preston at PR2 9HT, adjacent to the hospital accident and emergency department.

The service provides a fully integrated service including all aspects of urgent primary care, provided 24 hours a day, seven days a week. The service integrates out-of-hours care, an urgent care centre, a deep vein thrombosis pathway service and a pathway alternative to transfer (PAT) service. (The PAT service allows for the North West Ambulance service to refer patients to PIUCC who they had assessed as not being suitable for hospital admission, in order to provide advice or treatment to patients in their own homes).

The service is provided by GO To DOC Limited, also known as gtd healthcare, a not-for-profit organisation contracted by NHS Greater Preston clinical commissioning group (CCG). GO To DOC also provide a similar integrated service from the Chorley and South Ribble Hospital. All services in Preston started in November 2016 except for the urgent care services which started in January 2017. Initial data for the services show that the total number of patients seen since November 2016 is in excess of 34,500.

The service is located in rooms situated on the ground floor of the Royal Preston Hospital which are leased from them. It comprises triage and treatment rooms, patient waiting areas, reception desks and a reception office. The service utilises the hospital car parking for patients with the first 30 minutes free; parking after that is pay and display. The waiting areas in the service are large, and there is suitable seating for patients; there are arrangements for children to wait separately. The main waiting area is shared with the hospital orthopaedics clinic. A re-development of the premises is planned to start in November 2017.

According to the Public Health England health profile for Preston published on the 4 July, 2017, the health of people in Preston is generally worse that the England average. Preston is one of the 20% most deprived districts/unitary authorities in England and about 23% (6,200) of children live in low income families. The life expectancy for both men and women is lower than the national average. Many ethnic groups live in Preston and the number of people from an ethnic minority group is 13.2% of the population.

The service is GP-led employing both salaried and sessional GPs. Staff at Preston are also made up of an advanced care practitioner, a nurse practitioner, urgent care practitioners, a registered nurse, healthcare assistants, an operations facilitator, drivers and receptionists. Some staff are shared with the service at the Chorley and South Ribble Hospital

location. They are assisted by care co-ordinators and the GO To DOC management and administration teams based in Denton, Greater Manchester. Both clinical and non-clinical staff have lead roles in the organisation.

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 service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 12 October 2017. During our visit we:

- Spoke with a range of staff including the chief executive, five clinical lead staff (including one GP and four nursing staff), one sessional GP, one advanced practitioner, one urgent care practitioner, two clinical pharmacists and two health care assistants. We also spoke to a receptionist, a driver, three members of the non-clinical management team including the head of governance, the general manager, and the corporate administrative manager, and three further members of the service administration team.
- Observed how staff interacted with patients at the reception desk and in the waiting area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the service used to deliver care and treatment plans.

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?

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform managers and/or the governance department of any incidents and there was a recording form available on the service's computer system. 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).
- From the sample of two documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The governance department ensured that all external services concerned with the event were included in discussions when applicable and shared all events with the quality manager at the clinical commissioning group (CCG). The service carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety. For example, following an event where a patient collapsed in the waiting room, the service reviewed arrangements for the management of patients who were experiencing a cardiac arrest. Although the event had been managed well, the service worked with the hospital emergency department and introduced a new procedure and re-arranged emergency equipment to improve processes in the future. They also sent information to the NHS 111 service so that they could carry out a significant incident investigation.
- The service also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff both online on the service intranet and also in a folder in reception office. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Staff were also encouraged to fill out a significant incident form following a safeguarding concern and we saw instances where this had been done. There were lead members of staff for safeguarding. We were told that GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. The service also ensured that clinicians followed up safeguarding concerns with the patients' own GPs. The service was able to identify vulnerable patients from special notes sent to them by the patients' own GPs. If the service had concerns about a child presenting to them, they were also able to ask the hospital A&E department to carry out checks on patient computer records that the service was unable to access. We were told that arrangements were in hand to enable better electronic liaison between the service IT system and the local child safeguarding service. The provider held quarterly internal safeguarding meetings and attended other local external safeguarding meetings.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received up-to-date training on safeguarding children and vulnerable adults relevant to their role.
- A notice in the waiting room and on the doors of clinical rooms, 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 service maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. The service had a contractual agreement with the hospital

for cleaning services and there were cleaning schedules and monitoring systems in place. The service healthcare assistants also carried out a daily visual check of the premises and equipment.

- There was an infection prevention and control (IPC) clinical lead who liaised with infection prevention teams to keep up to date with best practice. There were IPC protocols and policies and all staff had received up to date training. An IPC audit had been undertaken when the urgent care service had started in January 2017 and again in October 2017. We saw evidence that action was taken to address any improvements identified as a result. Some of the areas identified as needing improvement were to be addressed by a planned refurbishment which was due to start soon after our inspection.

The arrangements for managing medicines, including emergency medicines and vaccines, in the service minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Processes were in place for handling urgent prescription requests and there were comprehensive prescribing policies in place. The service medicines management team carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing and offered advice to non-medical prescribers. There were also spot checks of clinical prescribing carried out by the service clinical guardian whose role included the review of staff clinical practice. Blank prescription forms and pads were securely stored and there were systems to monitor their use. The service used good practice guidelines for prescribing over-the-counter medicines and was discussing the future use of certain Patient Group Directions with the CCG to allow nurses who were not prescribers to administer medicines in line with legislation.
- There were sealed boxes of medicines for use on home visits. These boxes were checked regularly and all medicines used were comprehensively monitored.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely including coded access to the medicines themselves. The service carried out regular audit of these medicines. There were also arrangements for the destruction of controlled drugs.

We reviewed four personnel files and found evidence that appropriate recruitment checks had been undertaken prior to employment for staff recruited by the service. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

We saw that the service maintained patient information and confidentiality. Patient diagnostic results were stored in a locked box before being taken off-site for safe storage. All staff were trained in information governance.

Home visits were available for patients when needed. Service-employed drivers drove GPs who undertook home visits. We saw that cars were in good condition with clear livery that indicated their purpose. Drivers were responsible for documenting medicines boxes and equipment and supplies taken out on visits and completing handover forms when returning to the service.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- The service had a contractual agreement with the hospital whereby all safety checks of the premises and equipment were carried out in a timely manner. There was a contracts manager who attended monthly meetings to discuss these agreements and who held a spreadsheet that detailed when checks were due.
- There was a health and safety policy available and regular risk assessments were carried out for the premises and staff working conditions.
- The service had an up to date fire risk assessment and participated in regular fire drills. There were designated fire marshals within the service. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. Electrical safety checks were carried out twice a year; the last check was in August 2017.

Good

Are services safe?

- The service had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The service used a demand and capacity tool for all areas of the service to assess the number of staff needed at different times and had an escalation plan to use if demand increased unexpectedly. We saw that they had responded to recent increased demand on Monday mornings and Sunday early evenings.
- The service had effective systems in place to ensure patients were safe if they could not be seen immediately by a clinician. The service aimed to provide clinical triage of patients within 15 minutes of their arrival. The service was carrying out further work with the hospital emergency department to reach a consensus regarding the outcome of this clinical triage according to the presenting condition of the patient. This work had been agreed and supported by the CCG.
- Children could wait separately in a different waiting area. If patients were waiting a long time (more than two hours for adults, more than one hour for children), the service formally re-assessed their condition. One of the service care-co-ordinators was designated to keep a watch on patients who were waiting to note any visual deterioration of condition and clinicians came to the waiting area to call patients themselves to ensure that they had a regular overview of patients waiting. There were also posters on display asking patients to make staff aware if they thought that a patient's condition was deteriorating. If staff were unsure about a patient they told us that they could consult with the hospital emergency department staff.
- The service provided cars for home visits. These cars were regularly maintained and their condition monitored regularly. They were clearly marked as GP cars and were well equipped for their purpose.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency packs ("grab bags") in all treatment rooms including emergency medicines and oxygen with adult and children's masks. All the medicines and equipment that we checked were in date and held securely and all staff knew of their location. The service resuscitation officer visited the site regularly to train staff and monitor emergency arrangements.
- The service had defibrillators available on the premises and in the event of an emergency, had an arrangement with the hospital emergency department that enabled them to summon the hospital resuscitation team.
- A first aid kit and accident book were available.
- The service had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Because the service operated at another location in neighbouring Chorley, this allowed for some resilience in operating the service. Managers had a rota to be on-call outside normal working hours and all had access to this plan.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The service had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE both online and by way of an application that could be used on mobile phones, and used this information to deliver care and treatment that met patients' needs.
- The service monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Protocols for prescribing medicines had been developed based on national and local guidelines.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement including clinical audit. The service had regular contract review meetings with the clinical commissioning group (CCG) to discuss how they were meeting the quality requirements set out in their contract. The service analysed the results of the quality monitoring and risk assessed the reasons for non-achievement. They produced an action plan to address this and we saw evidence that the service had made changes as a result. For example, the service addressed delays in the certification of patient deaths by a GP with an agreement with the CCG that certification could also be made by a service paramedic. They also were training senior nurses to be able to verify patient expected deaths.

We reviewed service performance against both national and local quality requirements. We saw evidence that the service was meeting the majority of the quality requirements.

Performance for the out-of-hours (OOH) service met or exceeded the set quality targets save in one area. For example, from the latest available figures for September 2017:

- The percentage of all OOH consultation details (including appropriate clinical information) sent to the patient's registered practice by 8am the next working day was 95% (target 95%).
- For urgent cases, the percentage of face-to-face consultations (irrespective of location) commenced within two hours of the clinical assessment being completed was 92% (target 95%).
- For non-urgent cases, the percentage of face-to-face consultations (irrespective of location) commenced within six hours of the clinical assessment being completed was 97% (target 95%).

For the urgent care service (UCC), the service performance was variable when compared to the local quality requirements. For example, from the latest available figures for September 2017:

- The UCC diverted 7% of patients back to the emergency department after they had been assessed as appropriate for the UCC, compared to the quality requirement figure of no more than 5%.
- The percentage of patients attending who were admitted, transferred or discharged within 4 hours of arrival was 99% (target 95%).
- The percentage of patients attending who were admitted, transferred or discharged within 2 hours of arrival was 76% (target 85%).

The service had produced a remedial action plan, shared with the CCG, to address areas of service where they were not achieving targets. This plan detailed work that related to introducing a better triage system based on national systems in conjunction with hospital staff and increased audit of clinical decision-making.

We saw evidence that the service to provide patients with an alternative to hospital admission had prevented 90% of those patients from attending hospital.

The service had also analysed the use of diagnostics to support the identification of patient health conditions. They had identified those diagnostics that were not recommended and shared results with clinicians to reduce diagnostic requests. Staff had also recognised that diagnostics were not always timely for some patients with suspected deep vein thrombosis (DVT) (a DVT is a blood clot that develops in a deep vein, usually in the leg). The service had been allocated a number of diagnostic appointments within the hospital each day, but these

Good

Are services effective?

(for example, treatment is effective)

appointments were not always at a time when the patient presented, or sometimes had been taken by hospital patients requiring urgent scans. We were told that this was being addressed and that a new contracted service to supply full leg scans for patients with a suspected DVT would start in November.

We saw evidence of further quality improvement including clinical audit. Audits were generally baseline audits due to the infancy of the service in Preston. The service had conducted an audit of the treatment of patients who presented with a sore throat to identify whether clinicians had followed best practice guidelines. There had also been two two-cycle audits, one of the management of patients with urinary tract infections and one for the prescribing of certain antibiotics, where improvements were put in place and then monitored. The service had also carried out regular monthly monitoring of the use of selected medicines against best practice guidelines where results were discussed and learning shared with clinicians.

The service participated in local audits, national benchmarking, accreditation and peer review.

Staff also identified patients who were contacting them frequently. The patient engagement manager telephoned them proactively twice a week to discuss their needs and offer support. We saw evidence that this had reduced calls to the service for one patient from more than 140 in the months of November 2016 to January 2017 to single figures since then.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The service had a comprehensive induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. There was a detailed induction pack for staff that set out all necessary service information including a list of key policies, medicines and their use and criteria for the management of patients in the urgent care centre.
- The provider relied on locum and self-employed GPs to fill staffing requirements. Managers told us that they wanted to employ more staff directly and that they were planning a recruitment drive for GPs in November 2017.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. They kept a matrix of training requirements for all staff and ensured that training was up-to-date. Training that had been undertaken outside the service was validated and certificates for this were attached to the training matrix as evidence of completion.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. The service revalidation lead provided training sessions for revalidating staff and those staff who had already revalidated had shared their portfolios with others. All staff who had been in post before the new service had started in November 2016 had received an appraisal within the last 12 months. New staff had had progress meetings with managers every two weeks since they started. Outstanding staff appraisals had been planned for completion. The service had also undertaken a training needs analysis and had organised a three-day training programme to address these needs. These included training on wound closure and the treatment of patient minor injuries. They had also identified development for staff that included a healthcare assistant training to become an assistant practitioner and training for staff taking patient bloods. Four clinical staff were training to become advanced practitioners increasing to five in the near future.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The service told us that they placed a high value on the provision of staff training and development and staff we spoke to agreed that this was the case.

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 service's patient record system and their intranet system.

- This included risk assessments, care plans, medical records and, if the patient was registered at practices linked to the service, investigation and test results. We

Good

Are services effective?

(for example, treatment is effective)

were told that work was underway to make full patient records available to the service using a data sharing agreement between the service and patients' GP practices.

- "Special notes" were used by GP practices to inform the service of vulnerable patients. These notes were added to the service patient record and kept in printed form in the operations room at head office for ease of access. The service told us that they were working with the CCG to be able to record and share patient preferences for end-of-life care electronically.
- The service shared relevant information with the patient's GP and notified the GP if they found a patient required an urgent referral to other services. Staff ensured information was forwarded by clinical letter or shared electronic systems, which included when patients needed to be referred. GPs told us that in urgent circumstances they telephoned the patient's GP directly. Information was shared with GPs from the out-of-hours service by 8am the next morning and the service monitored this to ensure that it happened.
- If patients needed to be transferred to the hospital, the service printed off the necessary patient notes to accompany the patient.
- During the time when the patient's GP practice was closed, if the service received patient results of diagnostic tests that indicated that urgent treatment was needed, the service contacted the patient directly.
- The service had two shift leads, one for urgent care and one for its out-of-hours service who communicated when one service took over from the other using a nationally recognised communications tool. This handover was recorded and stored on the service intranet for easy access.

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 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support. For example, patients receiving end of life care, carers, those with a mental health condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service or were given patient information literature. The service had also developed some of their own information leaflets for patients. Staff were able to refer directly to some other services such as medical assessment beds, the local frailty service, the drug and alcohol service and to social services for assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff maintained an overview of patients waiting to ensure that they were as comfortable as possible.

We received 27 patient Care Quality Commission comment cards. Of these, two did not relate to the integrated service, but to hospital services. The remaining 25 cards we received were positive about the service experienced. Patients said they felt that they were offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Three of the comment cards also said that waiting times could be improved. Other patient comments said that staff were both friendly and professional and that, in relation to the treatment of children, they were put at ease by staff and treated quickly and efficiently.

The service had conducted its own survey during April to September 2017. We saw that of the 42 patients who responded, 37 (88%) of patients said that the staff they spoke to were polite and courteous, 35 (83%) stated that they felt reassured by the clinician they saw or spoke to and 40 (95%) said that they felt that they were treated with dignity and respect by the staff.

The patient engagement manager worked proactively with patients who contacted the service frequently to address their needs and reduce the number of times that they needed to contact the service.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received was positive and said that patients felt listened to and supported by staff. They said that they could make an informed decision about the choice of treatment available to them and also that staff kept them informed about what was happening while they were waiting for treatment.

Children and young people were treated in an age-appropriate way and recognised as individuals. There was a separate waiting area for children and staff were trained in the care and treatment of children.

The service provided facilities to help patients be involved in decisions about their care. Staff told us that interpretation services were available for patients who did not have English as a first language and this service was advertised in the waiting area to patients. Staff were also aware of the value of face-to-face, clear communication with patients. Patients who had hearing, visual or learning difficulties were highlighted on the patient electronic record. Patient preferences for communication methods were also recorded when possible.

The service was using the "equality delivery system 2" (EDS2) process to assess all of its policies and procedures (the main purpose of EDS2 is to provide a tool to help NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010). The process was being conducted at board level and was nearing completion.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with the clinical

commissioning group (CCG) to secure improvements to services where these were identified. Patients' individual needs and preferences were central to the planning and delivery of the service. Staff from the service integrated with other healthcare providers to develop partnership care planning for patients across the local health economy. For example, staff worked with the hospital emergency department to develop patient pathways for identified patient problems. The CCG had also asked them to initiate a minor injury service for patients, and clinicians had been trained over a period of three days to provide this service. At the time of our inspection, this had been suspended because of difficulties in meeting the demands that the service placed on the hospital diagnostic services. It was hoped that this could be resolved in the future.

The service offered access at the integrated urgent care service to patients during normal GP practice opening hours as a first point of contact for patients who self-presented to the service for emergency, unscheduled care and for those patients who had been assessed by the ambulance service as being suitable for primary care. The service also provided medical input as an alternative to hospital attendance for patients who had dialled 999 and had been assessed by the local north west ambulance service (NWAS) as not needing to attend hospital. This urgent care service was co-ordinated by the organisation head office taking calls from NHS111 or other healthcare professionals such as those from NWAS. Patients were either given booked face-to-face appointments or were telephoned by clinicians to be offered advice. The service had a comprehensive failed encounter policy to address cases where patient contact had not been able to be made. Home visits were carried out where appropriate. The organisation also offered a deep vein thrombosis (DVT) service which offered the assessment, diagnosis and treatment of patient DVTs (a DVT is a blood clot that develops in a deep vein, usually in the leg). Staff contacted all DVT service patients who did not attend for an appointment.

Data showed that the urgent care centre had treated more than 16,400 patients since January 2017 when it opened, the out-of-hours service approximately 14,800 patients since November 2016 when it opened and the alternative to hospital admission service more than 2,300 patients since November 2016. The DVT service had seen more than 1,000 patients since November 2016 when it opened.

- The service offered was also an out-of-hours service which patients could access by dialling NHS 111 when the GP surgeries were closed.
- There were accessible facilities, two hearing loops and interpretation services available.
- Staff would try to find a quiet room for patients with a learning disability for consultations and there was a separate waiting area.
- The service main waiting area was shared with the hospital orthopaedics department which often had many patients waiting. There were posters displayed in the waiting area to tell patients that not all patients were waiting for the integrated urgent care service. There were also approximate waiting times displayed which were regularly updated. The service was planning a re-development of all areas of the service premises which was due to start in November 2017.
- The patient engagement manager worked with patients who contacted the service frequently.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the service. GPs visited care home patients and at the time of our inspection, the service was finalising arrangements for the use of skype for some care home patient consultations.
- Patients were signposted to other services when applicable and were given advice as to what to do if their condition did not improve. The service was working with the hospital and the CCG at the time of our inspection to improve the referral process for patients needing other services, particularly unregistered patients, homeless patients and vulnerable patients.
- Staff took account of the needs and preferences of patients with life-limiting progressive conditions. There were medicines available out-of-hours for palliative care patients if needed and clinicians were trained in assessing the pain levels of patients.
- Children had their own waiting area and the service worked to ensure that they were seen within shorter timescales than adults.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients could select the most appropriate desk to check in to the urgent care service. There was one reception counter with a desk for patients who felt that they needed emergency treatment and two desks for patients wanting to access the urgent care centre. Clinicians at the service carried out all of the patient triage.

Access to the service

The service was open 24 hours a day, seven days a week. There was a dedicated phone line for other services, healthcare professionals and local care homes to contact the service directly.

Of the 25 CQC patient comment cards that we received, eight specifically mentioned the timely nature of the service with only three saying that the wait for treatment was long. Patients said that the service was efficient and valuable.

Clinical triage of patients indicated which patients should be classed as urgent and which were less urgent. Performance monitoring statistics showed that the timely management of patients during out of hours was generally achieved. Statistics for the urgent care centre were more variable, and while 99% of patients were seen and discharged, transferred or admitted within the four hour time limit, only 76% were seen and discharged, transferred or admitted within the two-hour time limit when the target for achievement was 85%. The service was working to improve this. They had conducted capacity and demand reviews to identify required staffing levels and updated the staffing structure to reflect the recommended staffing levels. They had also changed staff rotas and shifts to meet the required staffing levels with a greater shift overlap. At the time of our inspection, they were planning a recruitment drive so that more GPs could be recruited directly by the service rather than having to rely on locum staff.

Listening and learning from concerns and complaints

The service had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with NHS England guidance and their contractual obligations.
- There was a designated responsible person who handled all complaints in the service supported by the clinical governance department.
- The service monitored all complaints received and had seen a decrease in the number of complaints received since it opened in November 2016.

We looked at three complaints received since November 2016 and found they had been dealt with in a timely way and with openness and honesty. Both written and verbal complaints were recorded. We understood from the service that there had been many changes in the local provision of urgent and out-of-hours care at the time that the service was implemented which made it difficult to satisfy patient expectations. However, we saw that complaints had been treated appropriately. Lessons were learned from individual concerns and complaints and also from analysis of trends. Action was taken as a result to improve the quality of care. All complaints were discussed at clinical governance meetings and lessons learned were shared with staff. For example, the importance of communicating with patients waiting for treatment was stressed to staff following complaints by patients who waited a long time to be seen for treatment. A board that showed waiting times was introduced to the patient waiting area. Following a complaint from a deaf patient, the service had enlisted the help of deaf patients as "expert patients" to improve and develop services. Also, when complaints regarding clinical care were received, staff were asked to reflect on their practice and identify any learning points. This reflection was then reviewed by the service clinical lead. When complaints also involved other services, the provider ensured that they were included in the complaint resolution process.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

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

- This vision was "to inspire trust and confidence by making a positive difference every time".
- The service values were to:

"put patients first, look after our people, give great quality care, lead the way in transforming primary care, contribute to the wellbeing of our communities".

- The service had a business plan and strategy which they told us was flexible and allowed for responsive service development. This was evidenced in minutes of meetings and discussion with all members of staff as well as external organisations. We saw that this plan was built around the needs of patients.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. The leadership team consisted of both clinical and administrative staff. The organisation structure was made available to all staff and the service provided a "who's who" guide with a fun quiz to ensure staff were visible within the organisation. There was a checklist for staff as to who to contact for any issue and a page on the staff intranet, "Our People" which had profiles and pictures of staff with lead roles in the organisation. Profiles of individual staff were also shared in monthly staff bulletins.
- Service specific policies were implemented and were available to all staff both on the service intranet and also, for all key policies, in a folder in the reception office. These were updated and reviewed regularly at clinical governance meetings.
- A comprehensive understanding of the performance of the service was maintained. Local service meetings were held monthly which provided an opportunity for staff to learn about the performance of the service. Minutes of these meetings were kept on the service intranet. There was a care co-ordinator's folder kept in reception which was used for communications regarding the service, training and procedures. There was a strong clinical governance department that held two-monthly meetings with a set agenda for the discussion of quality issues such as significant events, complaints, service performance, actions resulting from changes to best practice guidance, changes to policy and clinical audits. Outcomes of discussions at clinical governance meetings were fed to the senior management team meetings. There was a quarterly clinical governance report which reported on all governance issues including clinical audit. At the time of our inspection, the service had started joint governance meetings with other organisations such as the hospital and had agreed the terms of reference for these. They also attended bi-monthly joint improvement meetings held with the hospital and chaired by the clinical commissioning group (CCG).
- The service had conducted reviews of the patient journey "end to end" with the NHS 111 service and the local ambulance service.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The service used recognised risk assessment tools to quantify patient demand and assess staff capacity daily in order to meet the needs of the service. Risks to service delivery were comprehensively assessed in all areas of the service. There were fortnightly meetings to discuss operational risks at the service head office so that, if necessary, risks could be escalated and action taken. Risks were also reported to the CCG.
- Staff met with the hospital emergency department staff three times a day in what they termed a "huddle" to respond to staffing and clinical pressures.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. These lessons were shared with other organisations when appropriate and with commissioners.

Leadership and culture

On the day of inspection the service leaders demonstrated they had the experience, capacity and capability to run the

Are services well-led?

Outstanding ☆

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

service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us that managers were approachable and always took the time to listen to all members of staff. Managers told us that they constantly sought ways to support staff, encourage them to feel part of the GO To DOC family and embrace their values.

The organisation also aimed to work closely with the local community and contribute to their wellbeing. We saw examples of this in other areas of the organisation and were told that similar work was planned in the Preston area.

There were opportunities to discuss clinical queries, staffing issues and peer review at fortnightly meetings attended by staff from the Preston and Chorley services and the hospital. The service also held coffee and cake mornings to involve other services in service development, such as the drug and alcohol service and the hospital X-ray department.

The provider was aware of and had systems 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. The leadership team encouraged a culture of openness and honesty. From the documented examples we reviewed we found that the service had systems to ensure that when things went wrong with care and treatment:

- The provider gave affected people reasonable support, truthful information and a verbal and written apology.
- The service kept written records of verbal interactions as well as written correspondence.

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

- Staff told us and we saw evidence that the provider held regular team meetings. All staff who worked for the organisation in that locality were invited, including locum staff. They told us that everyone who attended the meetings were paid for their time.
- Staff told us there was an open culture within the organisation and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for staff to view.
- Out-of-hours staff were supported by three staff leaders; an on-call manager, a clinical lead and a senior care co-ordinator.
- Staff said they felt respected, valued and supported, particularly by the leaders and managers in the service. All staff were involved in discussions about how to run and develop the service and were encouraged to identify opportunities to improve the service delivered by the provider. The organisation offered £25,000 each year as an innovation fund for staff to use for service development and improvement. Staff were invited to submit bids for ideas to improve their working environment or the patient journey which were then judged and the winners selected. Past winning bids were, for example, the provision of basic life support training for patients, the provision of a blood monitoring clinic for patients taking blood-thinning medicines, flowers or equivalent for staff on special occasions and a staff team building event.
- The service funded staff social events such as an "It's a knockout" day in April 2017 and a twentieth anniversary celebration party in March 2017.
- We saw a high level of staff satisfaction with the organisation and the provider was committed to developing staff to meet the changing needs of the service. For example, the service had invested in an on-line training package for staff and had provided training opportunities for staff following an analysis of training needs.

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

The service encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the NHS Friends and Family Test (FFT), the service's own surveys and complaints and compliments received. The service designed each survey depending on the results of the previous one to ensure that they were meaningful.
- staff through a series of listening events in June 2017. Members of the service board and communications department met with staff to get feedback on the

Are services well-led?

Outstanding ☆

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service and how their working environment could be improved. This was collated and given to the board and recommendations were made and acted on. For example, torches were added to drivers' bags and staff communications were improved in relation to service changes. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They told us that managers were both visible and approachable. There was a high level of staff satisfaction and staff told us they were proud to work for the service and that they felt involved and engaged to improve how the service was run.

- The service produced a monthly bulletin for staff to keep them informed. This included a "you said, we did" section. Examples of this in Preston were increased appointment times for the out-of-hours service of 15 minutes, and the design of the livery on the service cars.

Continuous improvement

The organisation was a not-for-profit organisation where all profits for services offered were put back into services.

There was a focus on continuous learning and improvement at all levels within the service. The organisation was forward thinking and had initiated schemes to improve outcomes for patients in the area. It was working with the hospital emergency department to agree pathways of care for different patient presenting conditions. The CCG had recognised and supported this initiative.

The service was innovative in offering a fully integrated service including all aspects of urgent primary care provided 24 hours a day, seven days a week. The service integrated out-of-hours care, an urgent care centre, a pathway alternative to transfer service and a deep vein thrombosis pathway service.

The organisation structured its workforce on patient needs. It found proactive ways to support this need by recruiting staff with different skills and developing existing staff. The service was planning further recruitment and was going to run a recruitment open day at the end of November 2017.

The provider was proactive in using technology to support the service delivery. They made use of nationally recognised IT systems and were engaged in enabling better access to local paediatric liaison and in utilising data sharing agreements with local GP practices. They had adopted an online training software system to enable better access to training for staff.

The service hosted two physician associates each year through an agreement with Health Education North West. These clinicians each had one year of supervision at the service.

The premises at Preston hospital were due to be re-developed starting November 2017 to improve patient facilities and increase the provision of patient treatment rooms.

The organisation had a history of engaging with the local community and told us that they planned to engage with the community in Preston in the future.