Norwich Practices Health Centre and Walk in Centre

Inspection report

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Date of inspection visit: 24 February 2022
Date of publication: 13/05/2022

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 location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

A summary of CQC findings on urgent and emergency care services

in Norfolk and Waveney.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Norfolk and Waveney below:

Norfolk and Waveney

Provision of urgent and emergency care in Norfolk and Waveney was supported by services, stakeholders, commissioners and the local authority. The health and care system in this area lies across a large, predominantly rural, geographical area with a large proportion of the population aged over 65 years.

Compliance with CQC regulations has historically been challenging across Norfolk and Waveney, particularly in Acute, Mental Health and Adult Social Care services, many of which have been rated Requires Improvement or Inadequate.

We spoke to staff in services across primary care, urgent care, acute, ambulance services, mental health and adult social care. Staff told us of increased pressure across urgent and emergency care pathways, staffing issues and a lack of capacity in key sectors including GP and Dental practices and social care. These issues were resulting in inappropriate calls to 999 and attendances in emergency departments.

There were delays in discharge for patients who were medically fit but unable to access appropriate packages of care to enable them to leave hospital.

We previously inspected mental health services in the Norfolk and Waveney area in November and December 2021 and found, due to an increase in referrals and staffing shortages, patients in the community had long waits to be seen. This led, in some cases, to patients deteriorating and requiring urgent and emergency treatment. In addition to this, some inpatient services (such as CAMHS) did not have available beds within the area. Patients were kept in urgent and emergency care settings whilst a bed was found.

During inspections of acute services, we found patients unable to access appropriate and timely care to meet their mental health needs.

We inspected a number of GP practices and found some concerns in relation to access for patients trying to see or speak to their GP. We found high levels of staff absence resulting in some staff working long hours and experiencing increased pressure on their services.

To try and alleviate the increasing demand on Emergency Departments, GP streaming services had been introduced in EDs in Norfolk and Waveney. Patients who presented at the ED with problems which were deemed suitable for a primary care appointment could be referred to a co-located primary care service. In some cases, streaming services helped to prevent up to 33% of patients attending the ED.

We inspected urgent care services in the Norfolk and Waveney area and found these to be well-run. However, an on-going shortage of out of hours and urgent care appointments, particularly for urgent dental care, meant patients couldn't always be appropriately signposted by NHS111. This meant patients often presented to ED for treatment. NHS111 in

Overall summary

Norfolk and Waveney had also experienced significant staff shortages, much of which has been due to the COVID-19 pandemic. Leaders in this service had a recovery plan in place; however, staff shortages and increased demand had resulted in significant delays in call answering and call-back times in comparison to the national targets and there was also a very high call abandonment rate, meaning people ended the call before speaking to an advisor. Whilst performance across Norfolk and Waveney did not meet national targets and people experienced significant delays, these delays were, on average, shorter than regional and national averages.

We inspected emergency departments (ED) in Norfolk and Waveney between December 2021 and February 2022 and found lengthy delays for people accessing emergency care. A high number of patients were waiting over 12 hours in ED resulting in overcrowding. This impacted on ambulance handovers and further delays in releasing ambulance crews into the community to respond to 999 calls.

Staff shortages have had a significant impact on social care services across Norfolk and Waveney. In addition, the provision of domiciliary care services is challenging due to the rurality of the area. At the time of our inspections, a care hotel was being utilised in Norfolk and Waveney. We spoke to healthcare professionals who had provided services to people being cared for at the hotel and found them to be safe and generally well cared for. The number of people receiving care in the hotel was small and the aim was for them to only stay for a very short amount of time before going home. This service is commissioned until the 30 April 2022, a formal evaluation will take place before any future plans are agreed.

Some social care and learning disability services in Norfolk and Waveney have struggled to achieve compliance with CQC regulations and a rating of good. Some support has been established across Norfolk and Waveney to help services improve. However, the impact of any support to date has been limited.

Staff shortages and service quality has significantly reduced capacity across social care and learning disability services in Norfolk and Waveney. This has resulted in significant delays in transferring people from hospital to their own home or an appropriate place of care. This in turn meant people who were medically fit for discharge remained in hospital delaying the admission of new patients. These delays and poor flow resulted in overcrowded EDs and an inability to transfer patients from ambulances.

Strategic, system wide workforce planning and increased community provision of health and social care is needed to meet the needs of the local population. This is needed to reduce the pressure on urgent and emergency care services and to reduce the risk of harm to people living in Norfolk and Waveney.

We carried out an announced focused inspection at Norwich Practices Walk-in Centre on 24 February 2022. This focused inspection was carried out using our Pressure Resilience methodology which meant that we did not use all the key lines of enquiry and the report has not been rated.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

Overall summary

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Norwich Practices Health Centre and Walk in Centre

Norwich Practices Health Centre and Walk in Centre is located in the heart of the City of Norwich. The provider is Norwich Practices Ltd.

The practice provides primary medical services to a diverse patient population that are generally younger than average.

The walk-in centre is not registered with CQC separately from the GP practice, but we only inspected the walk-in centre. The walk-in centre service is commissioned by NHS England.

The walk-in centre is open 365 days a year from 7am to 9pm. Patients do not have to be registered with this GP practice or any other practice and are free to walk-in without an appointment. The service is open to adults and children.

The centre treats minor illness and injury and deals with sexual health matters, contraception, blood pressure checks and holds a phlebotomy clinic from 8am to 12.30pm Monday to Friday.

The service has approximately 6,000 patient contacts a month (200 daily), which is back to pre-pandemic levels, there having been a decline during 2021

Inspected but not rated

Are services safe?

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training.
- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. There was access to safeguarding alerts on GP records. There was a named nurse lead for safeguarding.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Consultation rooms displayed a flow chart to assist staff should they need to make a safeguarding referral.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The provider ensured that facilities and equipment, including the emergency drugs and equipment for use in a medical emergency were safe and that equipment was maintained according to manufacturers' instructions.
- There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. and an effective system in place for dealing with surges in demand. Core staff from other services were able to cover as demand dictated. There was always at least one GP on-site.
- There was an effective induction system for all staff, including temporary staff, tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. All patients entering the walk-in clinic were triaged upon entry by a clinician and prioritised according to clinical need. Observations of patients entering the building was carried out by a front door triage nurse.
- Appointments were allocated on a clinical risk basis and under 5-year olds were prioritised.
- Staff knew how to identify and manage patients with severe infections, for example sepsis.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- The service had developed bespoke protocols for mental health and substance abuse presentations.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Inspected but not rated

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw were of high quality, detailed and showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Approximately 95% of patients home GP practices were using the same clinical system which enabled information sharing to be simple and straight forward.
- Admission letters were printed out for patients to take with them to hospital.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. This included individual feedback to those staff involved.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service.

Inspected but not rated

Are services effective?

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided.

- There were no nationally recognised key performance indicators with which to compare the performance of walk-in centres. We spoke with the commissioners of the service who had no issues with performance and made no negative comments in this respect.
- The number of patients had increased to slightly exceed the pre-pandemic levels of approximately 6,000 patients a month.
- The lead GP and other staff we spoke with said they were happy with the workload and that there had only been a few occasions when they felt 'overloaded'.
- Staff expressed very positive views on teamworking within the staff and the quality of patient care.
- The service made improvements using completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. A GP we spoke with told us they received personal monthly feedback around the quality of their consultations.

Coordinating care and treatment

Staff worked together and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services and when they were referred to secondary care. If patients consented staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- Providing patients gave consent, an electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support, for example the frail elderly but his was not the services main demographic, as they tended to be younger people.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs. Patients referred to secondary care were given a printed copy of their admission letter.
- Access to dental services was noted as a problem, even after clinical review by a GP or nurse showing that dental referral was required.

Inspected but not rated

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- We were given examples of instances where the service had funded taxi's for patients needing hospital transfer but not requiring an ambulance and with no access to their own transport.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- The service monitored the process for seeking consent appropriately.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. They were focused on the walk-in contract ending and what a new commissioned service might look like.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. There was a regime in place to ensure regular testing of staff for covid-19.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended, for example, there was no lone working.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions by the nurse clinical lead. This included audit of induvial clinicians prescribing practice.
- Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance. Performance was regularly discussed at senior management and board level. Performance was shared with the local CCG as part of contract monitoring arrangements.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.