Shropshire Walk-In Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services effective?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Shropshire Walk-In Centre on 29 September 2016. Overall, the service was rated as requires improvement but good for providing a safe, responsive and caring service. The full comprehensive report on 29 September 2016 inspection can be found by selecting the 'all reports' link for Shropshire Walk-In Centre on our website at www.cqc.org.uk.

We undertook a focussed follow up inspection on 15 May 2017 to check that improvements had been made. The practice is now rated as good overall with requires improvement in providing a well led service.

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

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Risks to patients were assessed and well managed.
- Patients' care needs were assessed and delivered in a timely way according to need.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- There was a system in place that enabled staff access to patient records, and the out of hours staff provided other services, for example, the local GP and hospital, with information following contact with patients as was appropriate.
- The service managed patients' care and treatment in a timely way.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- The service had not ensured receipt of all appropriate patient safety and medicine alerts to enable appropriate action to be taken.
- They had not implemented a system, which follows NHS Protect Security of prescription forms guidance.

Summary of findings

The areas where the provider must make improvement are:

- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity by ensuring receipt of all appropriate patient safety and medicine alerts to enable appropriate action to be taken.
- Ensure a system is in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity by ensuring they implement a system that follows NHS Protect security of prescription forms guidance.

The areas where the provider should make improvement are;

- Document learning from events including positive events.

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 effective?

Good

The service is rated as good for providing effective services.

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- There was evidence provided to demonstrate that quality improvement activity was driving improvement in patient outcomes.
- Clinicians provided urgent care to walk-in patients based on current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services well-led?

Requires improvement

The service is rated as requires improvement 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.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity. The service was about to commence regular monthly governance meetings with their co-located A&E colleagues.
- There was an overarching governance framework, which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. There were a few exceptions, which included; ensuring receipt of all appropriate patient safety and medicine alerts to enable appropriate action to be taken, to fully implement a system that follows NHS Protect Security of prescription forms guidance.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The service proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

Shropshire Walk-In Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Shropshire Walk-In Centre

Shropshire Walk-In Centre provider organisation is Malling Health who joined with IMH Group during 2015 and is registered with the Care Quality Commission (CQC). The Walk-In-Centre was located in Whitehall, Monkmoor, Shrewsbury and runs alongside Whitehall Medical Practice under an Alternative Medical Provider Services (APMS) contract. The practice provided both a traditional GP service for registered patients at Whitehall Medical Practice with a walk in element for any patient. In December 2014, a contract variation took place that led to the GP practice remaining in Monkmoor, Shrewsbury and the walk in element of the service moving to the Royal Shrewsbury Hospital A&E department. This inspection is of the service provided at the Shropshire Walk in Centre only.

Shropshire Walk In Centre is open from 8am to 8pm every day of the year. During the services opening times reception staff, employed by Malling Health/IMH Group, work within the local hospital's A&E reception area booking patients into the service following triage completed by the A&E nursing staff, which changed in July 2016 to a 'Patient streaming protocol'. The commissioners of the service set out the range of expected patient conditions to be seen which includes a list of minor illnesses. The service does not routinely order blood tests or x-rays for walk in patients. If a test is required, patients are referred back to their own GP. If an urgent referral to a speciality is needed, patients are referred to either to their own GP or back to A&E.

The Shropshire Walk In Centre staffing consists of a lead GP (female) giving 0.2 whole time equivalent (WTE) hours, a regular sessional GP providing ad hoc hours when required and a team of six regular locum GPs. There are two Advanced Nurse Practitioners (ANP) providing 1.2 WTE hours, a Nurse Practitioner and two female Healthcare Assistants (0.2 WTE). There is an ANP vacancy for 0.8 WTE hours. The service is supported by a Practice Manager (1 WTE across two locations) and an assistant Practice Manager (1 WTE) and a senior receptionist with four reception/administration staff .

Why we carried out this inspection

We undertook a comprehensive inspection of Shropshire Walk-In Centre on 29 September 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The service was rated as requires improvement for providing effective and well led services.

We undertook a further focussed follow up inspection at Shropshire Walk-In Centre on 15 May 2017. This inspection was carried out to ensure improvements had been made.

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.

Detailed findings

During our visit we:

- Spoke with a range of staff (Practice Manager, Assistant Practice Manager, Quality and Compliance Manager, Medical Director North region, two GPs, and senior receptionist and receptionist).
- Observed how patients were provided with care.
- Inspected the premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- We reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.

Please note that when referring to information throughout this report, for example, any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 29 September 2016, we rated the practice as requires improvement for providing an effective service as we found the service had not:

- Ensured quality improvement activity and monitoring of prescribing which is specific to the Walk In Centre service.

We undertook a focussed inspection on 15 May 2017. During the inspection, we found that progress had been made and improvements were found in the services quality improvement activity and monitoring of prescribing. The service is now rated as good for providing an effective service.

Effective needs assessment

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

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The clinical staff had access to various best practice clinical websites, their electronic systems utilised clinical templates to enable staff to follow best practice guidelines.
- The service monitored that these guidelines were followed.
- Malling Health/IMH provider organisation monitored that these guidelines were followed through risk assessments and random sample checks of patient records.
- The service was in contact with the Rapid Assessment, Interface and Discharge (RAID) service, which is a specialist multidisciplinary mental health service, working within all acute hospitals for the referral of patients with mental ill health, which included those on medicines, which require specific monitoring. This improved access for patients without need of a referral from their own GP.
- The reception staff were co-located with NHS A&E staff at the Royal Shrewsbury Hospital. A form of triage entitled 'patient streaming' was led by qualified secondary care nursing staff as a failsafe process to ensure patients attended the most appropriate service to meet their needs. They completed baseline observations where appropriate when patients arrived at the service and had information relating to normal values and vital signs, which enabled them to easily escalate concerns to clinicians.

Certain groups of patients were excluded from being suitable for streaming to the service Exclusions included for example:

- Repeat attendances within 72 hours,
- All head injuries in children under six years old
- All traumatic injuries
- All foreign bodies
- All patients presenting with requiring intervention or investigation within the A&E department.

Robust clinical discussions were taking place between the Walk In Centre and A&E clinicians on the specific sub-protocols for the direction of babies under six months of age, feverish children under five and non-traumatic chest pain.

Management, monitoring and improving outcomes for people

From 1 January 2005, all providers of out-of-hours services have been required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group on their performance against standards, which includes audits, whether face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

The inspection in September 2016 found there was evidence of some quality monitoring in the patient searches completed by the provider such as time taken from the patient's point of contact at A&E to their consultation with clinical staff at the Walk In Centre. However, Shropshire Walk In Centre clinical staff had not completed any full cycle clinical audits to measure or improve the quality of care for this service. During the inspection in May 2017 we found that improvements had been made. For example;

Good

Are services effective?

(for example, treatment is effective)

- Patients were informed which service they had been assessed to receive.
- Subsequent to the Care Quality Commission inspection in September 2016 the local Clinical Commissioning Group had provided two data entry codes for the providers' locations prescribing data at Whitehall Medical Practice and Shropshire Walk In Centre. This enabled the service to monitor and differentiate between each of these locations and to review individual prescribed data, including antibiotic prescribing.
- They were participating in a local patient streaming initiative subject to review and benchmarking which commenced 18 July 2016. Streaming was simply to ascertain if the patient has an injury (stream to A&E) or an illness (potentially suitable for a GP service such as the Walk In Centre). Patient streaming was led by qualified secondary care nursing staff as a failsafe process to ensure patients attended the most appropriate service to meet their needs.
- During the inspection in September 2016, we found the service had not carried out quality improvement activity to improve patient outcomes and ensure improvements have been achieved, which include monitoring of the newly implemented triage system called the 'Patient streaming protocol.' In May 2017, we saw evidence that the service had audited the appropriateness of the initial steaming decisions taken by staff over a three-month period.

There was data available on the numbers of patients referred to the Walk In Centre who following consultation were referred back to A&E. For example, between January 2017 and March 2017 there was a total of 57 patients referred back to A&E. This included for example:

- 15 patients who required further investigations/tests
- 14 required a diagnostic x-ray service
- 12 required specific observation/clinical supervision over a period of time
- Six assessed as potential sepsis
- One required a hospital bed.

The service provided data to the local Clinical Commissioning Group (CCG). This data, for example, showed the numbers of patients who attended the Walk In Centre by date and whether the patient had consulted with a nurse or GP. These were cross-referenced year on year. The service was aware that they were dealing with fewer patient numbers and were reliant on the safe streaming of patients by secondary care to their service.

The service's own annual data showed that between January and March 2017, 2,943 patients were seen. In March 2017, 1085 patients were seen and attendance data for this month also demonstrated for example:

- 84% of patients had been seen in less than 30 minutes and of these, 60% of patients had been seen in less than 10 minutes. All patients with the exception of one patient who choose to leave the service were seen within less than 110 minutes.
- The majority of patients who attended had a Shropshire address (904). The other patients did not reside in the Shropshire area.
- Of the 1,085 patients seen in March 2017, 1009 patients were attending for the first time, and 57 patients attended two or more times, 19 attended three or more times, the majority of follow up appointments related to the provider's weekend dressings service.

In February 2017, 874 patients were seen and attendance data for this month showed:

- 81% of patients were seen in less than 30 minutes from time of arrival/streaming.
- 546 patient consultations lasted between 0 and 10 minutes.
- 21 patient consultations lasted between 0 and 20 minutes.
- 145 patient consultations lasted between 0 and 30 minutes.
- One patient consultation lasted between 0 and 110 minutes.
- The majority of patients resided in Shropshire (725).
- 64 patients had attended the Walk In Centre on two or more occasions, 6 patients had attended the Walk In Centre on three or more occasions.
- Of the 874 patients seen, 804 patients were attending for the first time.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. Advanced Nurse Practitioners (ANP) who undertook this role were signed off as competent and had received appropriate training in clinical assessment.
- 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. All staff had received an appraisal within the last 12 months or had an appraisal planned.
- 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, in-house training and external training sessions. The practice manager was able to identify were there were training gaps and prompt staff to attend training.
- Staff involved in handling medicines received training appropriate to their role.

Coordinating patient care and information sharing

The information needed to deliver care and treatment was available to relevant staff in a timely and accessible way through the provider's patient record system and their intranet system. Referral pathways and protocols were also in printed format on site in the clinical rooms for staff to refer to which included contact numbers.

- The service shared relevant information with the patient's GP and made calls to the GP when they found a patient required an urgent referral to other services, or referred them back to A&E where appropriate to do so. The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The service worked closely with the local hospital team who streamed patients to the most appropriate service to ensure that they met patients' needs. Patient streaming was led by qualified secondary care nursing staff as a failsafe process to ensure patients attended the most appropriate service to meet their needs. Therefore, patients could not simply choose to attend the Walk In Centre. Shropshire Walk-In-Centre was not responsible for the staffing of the nurse streaming in place and did not control referrals into the service.
- Staff ensured information was forwarded by clinical letter or shared electronic systems, which included when patients needed to be referred, or following discharge. For example, their contractual obligations included that patients would undergo an initial assessment and be referred, only where appropriate, using the General Medical Council (GMC) principles of Good Medical Practice (2006) unless specific referral pathways had been otherwise agreed. The GMC is a public body that maintains the official register of medical practitioners within the United Kingdom.
- The provider worked collaboratively with other services. Patients who could be more appropriately seen by their registered GP or an emergency department were referred. If patients needed specialist care, they could refer to specialties within the hospital. The clinicians had direct admission rights with protocols in place for this. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.

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.

Good

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear, clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 29 September 2016, we rated the practice as requires improvement for providing a well led service as we found the service had not:

- Ensured there was clinical leadership capacity to deliver all improvements.
- Implement formal significant event/complaint trend analysis with Walk In Centre clinical staff.
- Ensured that safeguarding policies fully reflect the procedures staff follow.
- Considered an accident book/documentation for Shropshire Walk-In Centre's own staff.
- Provided patient literature about the service including, complaint literature and information on the triage system in place.
- Engaged and communicate the service's vision and strategy with staff involvement.
- Considered measures to inform patients of anticipated waiting times.

We undertook a focussed inspection on 15 May 2017. During the inspection, we found that progress had been made and improvements were found in all these areas. However, different areas were found to require improvement.

Vision and strategy

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

- The staff knew and understood the vision and values.
- The organisation had a strategy and business plan that reflected the vision and values and these were regularly monitored. The service had a Midlands Regional practice manager meeting planned for 16 May 2017 in which the agenda had included an organisational update, a company overview and their business model. The agenda also included clinical updates, structure and development and their key deliverable objectives.
- We saw evidence of the organisation's development of a compliance calendar for 2017 to 2018 outlining areas to audit. For example in April the focus was workforce minimum data submissions, Control of Substances Hazardous to Health (COSHH) and risk assessment reviews. This was in the process of being rolled out to the organisation's various locations including Shropshire Walk In Centre.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. One of the organisation's Medical Directors, North Region as defined by the provider was contactable for peer, clinical and pastoral support.
- Service specific policies were implemented and were available to all staff.
- The provider had a good understanding of their performance. These were in the process of being discussed and reviewed with the local Clinical Commissioning Group. They were also discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- The service was about to commence regular monthly governance meetings with their co-located A&E colleagues.
- The service had made provision for formal significant event/complaint trend analysis with Walk In Centre clinical staff. The learning from a positive significant event was not documented. The practice manager following the inspection completed the learning element and forwarded this to the Care Quality Commission. They found that what had worked well was efficient streaming and prompt clinical assessment by clinical staff at the Walk In Centre led to timely discussions with A&E and the patient being quickly referred back to A&E and had surgery within 40 minutes of arrival. What was not clear was how they would use the learning from this event to further improve the service.
- The service had safeguarding policies that reflected the procedures staff follow.
- The service had an accident book/documentation specifically for Shropshire Walk-In Centre's own staff.

Are services well-led?

Requires improvement

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

- There was evidence of patient literature about the service including, complaint literature and information on the triage/streaming system in place.
- The reception staff after the patient had been assessed informed patients of which service they were assessed as requiring, for example, the Walk In Centre or A&E.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, we found that the service had not been in receipt of more recent appropriate patient safety and medicine alerts to enable them to take appropriate action. During the inspection the practice manager re-signed up to the relevant alerts. They forwarded, following the inspection, a spreadsheet to demonstrate this had taken place with documented actions taken. We reviewed this and found gaps remained in the information they had received and reviewed.
- We found that due to the recent 'cyber-attack' on some electronic systems in the NHS the service had followed their procedures and protocols. It had highlighted however, that hand written prescription pads did not have a system in place to monitor their use. During the inspection, the practice manager implemented a spreadsheet to commence this process.

Leadership and culture

The service told us they prioritised safe, high quality and compassionate care. Staff told us clinical staff were approachable and always took the time to listen to all members of staff.

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

- The service gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

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

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included email updates, one to one meetings and peer-to-peer discussions.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the providers. Staff had the opportunity to contribute to the development of the service.

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

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

- The service had gathered feedback from patients through the Friends and Family Test (FFT), which were all positive about the service they had received.
- The service had gathered feedback from staff through staff one to one discussions generally through appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in how to improve how the service was run.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements; Ensure receipt of all appropriate patient safety and medicine alerts to enable appropriate action to be taken. Fully implement a system, which follows NHS Protect Security of prescription forms guidance.