King Street Health Centre

Inspection report

47 King Street
Wakefield
WF1 2SN
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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 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

We carried out an announced focused inspection of King Street Health Centre on 5 April 2022. We undertook this inspection as part of a system-wide inspection looking at a range of urgent and emergency care providers in West Yorkshire. This was an unrated inspection.

A summary of CQC findings on urgent and emergency care services in West Yorkshire.

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 West Yorkshire below:

West Yorkshire.

Provision of urgent and emergency care in West Yorkshire was supported by multiple provider services, stakeholders, commissioners and local authorities.

We spoke with staff in services across primary care, integrated urgent care, community, acute, mental health, ambulance services and adult social care. Staff continued to work under sustained pressure across health and social care and system leaders were working together to support their workforce and to identify opportunities to improve. System partners worked together to find new ways of working, linking with community services to meet the needs of their communities; however, people continued to experience delays in accessing care and treatment.

During our inspections, some staff and patients reported difficulties with providing and accessing telephone appointments in GP practices. Some of these issues were caused by telephony systems which were being resolved locally. We found inconsistencies with triage processes in primary care which could result in people being inappropriately signposted to urgent and emergency care services. However, a number of staff working in social care services reported good engagement with local GPs.

We visited some community services in West Yorkshire and found these were generally well run. Service leaders were working collaboratively to identify opportunities to improve patient pathways across urgent and emergency care. These improvements focused on meeting the needs of local communities and alleviating pressure on other services. There were strong partnerships with social care and community teams, so patients had the right support in place on discharge.

However, we inspected one intermediate care service and found it could only take referrals from an acute trust, which meant there were no step-up facilities for patients in the community. The service struggled for ward space to deliver therapeutic activities and there were no communal spaces for patients to meet together or engage in group therapy. Plans were in place to provide additional facilities and to reconfigure the existing layout to provide communal spaces.

The NHS111 service was experiencing significant staffing challenges and were in the process of recruiting a high number of new staff. Staff working in this service had experienced an increase in demand, particularly from people trying to access dental treatment although a system was in place to manage the need for dental advice and assessment. Due to demand and capacity issues, performance was poor in some key areas, such as providing a call back to patients from a clinician.

The ambulance service had an improvement programme in place focused on performance and staffing. Whilst we saw some improvement in ambulance response times and handover delays, performance remained below target. We

Overall summary

identified impact on other services due to the availability of 999 responses; for example, a maternity service had to close temporarily to keep women safe, due to system escalation and because ambulance responses couldn't be guaranteed in an emergency. Staff working in social care services also experienced lengthy delays in ambulance response times which further impacted on their ability to provide care to their residents.

We inspected some mental health services in Wakefield which were delivering person-centred care and responded to urgent needs in a timely way. Staff worked in multi-disciplinary teams and collaborated with system partners.

People's experiences of Emergency Departments were varied depending on which service they accessed. Some Emergency Departments had long delays whilst others performed relatively well. In services struggling to meet demand, patient flow was a key factor. Poor patient flow was primarily caused by delays in discharge with a high number of people fit for discharge unable to access community or social care services.

Staff working in some social care services reported significant challenges in relation to unsafe discharge processes, this included a lack of information to support their transfer of care and we were told of examples when this resulted in people having to return to hospital. Local stakeholders had a good understanding of this problem and were looking to improve pathways and discharge planning.

Staffing and capacity issues in both care homes and domiciliary social care services have at times impacted on timely and safe discharge from hospital.

We found services were under continued pressure and people experienced difficulties accessing urgent and emergency care services in West Yorkshire. System and service leaders across West Yorkshire were working together to seek opportunities for improvement by providing services and pathways to meet people's needs in the community; however, progress was needed to demonstrate significant improvement in people's experience of accessing urgent and emergency care.

At the inspection of King Street Health Centre we found:

- The service had systems in place to manage risk so that if safety incidents occurred, they were investigated and any learning from them was shared and used to improve the service and prevent the recurrence of similar issues.
- Safeguarding systems, processes and practices had been developed, implemented and communicated to staff to manage risk and ensure patient safety.
- Staff informed us that they had access to policies, procedures and guidance relevant to their role and responsibilities including clinical protocols and guidance.
- The provider had appropriate clinical equipment in place to enable the effective assessment of patients. The provider also had the necessary equipment and medicines available to deal with medical emergencies including emergency resuscitation equipment.
- Infection prevention and control was appropriately managed to help safeguard people from COVID-19 and healthcare associated infections.
- There were arrangements in place for planning and monitoring the number and mix of staff needed. There was also an effective system in place for dealing with surges in demand. The provider supported the training of advanced care practitioners to increase clinical capacity.
- There were processes in place to coordinate, monitor and respond to the clinical needs of presenting patients.
- Clinical records viewed showed that care and treatment was provided safely, effectively and in accordance with evidence-based guidelines. The provider had systems in place to audit consultations and prescribing practices.

Overall summary

- Quality and performance was routinely monitored and records indicated that the service was performing well against key performance indicators such as initial assessments, and completion of care.
- The provider had an effective governance system in place that enabled ongoing monitoring and scrutiny of the operation and performance of the services provided. We saw that meetings were regularly held at both an operational and a senior management level.
- There were effective communication systems in place to facilitate information sharing across the organisation.
- Staff had access to induction, training and development opportunities. We saw that staff had received regular supervision and support and were subject to appraisal.
- There was a focus on continuous learning, improvement and innovation. This included via a programme of clinical and non-clinical audits, and participation in several pilot initiatives to improve local access to care.

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 nurse specialist adviser, and a second CQC inspector.

Background to King Street Health Centre

King Street Health Centre is a nurse-led walk-in service that is situated at 47 King Street Wakefield WF1 2SN, in the centre of the town. The centre is operated by Local Care Direct Limited, a social enterprise which delivers a range of health services including out of hours and some NHS 111 services across West Yorkshire and parts of North Yorkshire. Local Care Direct Limited operates from Sheridan Teal House, Longbow Close, Pennine Business Park, Bradley, Huddersfield HD2 1GQ.

The King Street Health Centre building is accessible to those with a physical disability and is served by a staircase and passenger lift. Access into the building is gained via a door intercom.

Being located in the centre of Wakefield there is no on-site parking, although there are public car parks nearby.

The service is commissioned by NHS Wakefield Clinical Commissioning Group (CCG).

The walk-in centre is open from 10am to 10pm 365 days of the year. As a nurse-led walk-in centre most members of the general public can attend the service to receive services in relation to:

- Minor illness
- Minor injury
- Dressings
- Emergency contraception

There are agreed exceptions, and these include:

- Babies under the age of six months
- Pregnant women presenting with a pregnancy related problem
- Repeat prescriptions
- Head injuries in Children under 2 years and in adults over 65 years old

Patients who attend the service during weekdays are assessed and prioritised for treatment and when necessary are supported to access other services such as accident and emergency, or appointments with other GP service providers.

The centre's clinical staff team consists of one clinical lead, six advanced nurse practitioners, two trainee advanced care/clinical practitioners, and a clinical support worker. The clinical team is supported by GP educators/trainers, a management team, and a reception and administration team.

The centre works closely with other local services including the extended access provider, and the local hospital trust.

King Street Health Centre is registered with the Care Quality Commission to deliver services in relation to:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

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 had processes and procedures in place to manage health, safety and welfare within the service. Staff received safety information from the provider as part of their induction and at refresher training. Systems to safeguard children and vulnerable adults from abuse were in place. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. In addition, staff were able to report concerns remotely via an electronic reporting system. Safeguarding reports were run on a monthly basis, reviewed at the service's internal quality meeting, and reported to the provider's Board annually.
- The service worked with other agencies as necessary to support patients and protect them from neglect and abuse. 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 safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. 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 (IPC). An IPC audit had been undertaken in September 2021; this showed high levels of compliance with required standards. We saw that any identified actions from the audit had been evaluated and completed within an appropriate timescale.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.
- The service reported that they had satisfactory supply levels of personal protective equipment.

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. There were systems in place for dealing with surges in demand. We saw that staff rotas were planned up to three months in advance. Staffing levels and pressures on the capacity of the service were closely monitored. The service had developed demand management processes to effectively meet challenges. This included the utilisation of staff who were able to multi-task and cover a number of work areas, and through using resources from other parts of the wider organisation.
- The service had processes and procedures in place to categorise and manage risk, this included:
  - Use of clinical support workers who carried out baseline observations on presenting patients within 15-30 minutes of patient arrival.
  - Use of National Early Warning Scores (NEWS a score used to identify acutely unwell patients, and which allows the prioritisation of such patients for care and treatment).
- Implementation of Operational Pressures Escalation Levels protocol to manage risks to clinician and patients in periods of high demand (a nationally recognised framework used to provide a consistent approach in times of pressure within the health and care system).
- There was an effective induction system for temporary staff which was tailored to their role.

Inspected but not rated

Are services safe?

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. The provider had systems were in place to manage people if they were to experience long waits or needed to be seen by other services such as emergency departments.
- Staff told patients when to seek further help. They advised patients and parents of children what to do if the presenting condition got worse. We saw from a search of patient records that safety netting procedures were in place and noted in records.
- The provider liaised with the GP practices of patients who frequently used the service to ensure effective management of the patient when they presented.

Information to deliver safe care and treatment

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

- Individual treatment records were written and managed in a way that kept patients safe. The records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. We also saw that the provider carried out audits of consultations and had put in place processes for improvement should this be identified.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

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 informed us that they understood their duty to raise concerns and report incidents and near misses, and were fully aware how to raise these. Managers supported them when they did so. In the previous six months the service had recorded 28 significant events. We saw evidence to show that these had been investigated, and learning shared when appropriate. Such incidents and events were reported to the internal quality group which met on a monthly basis.
- 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.

Inspected but not rated

Are services effective?

Monitoring care and treatment

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

- The service used key performance indicators (KPIs) that had been agreed with the clinical commissioning group to monitor their performance and improve outcomes for people. The latest figures for January 2022 showed that:
  - 100% of people who arrived at the service received an initial assessment within 15 minutes.
  - 99.7% of people who arrived at the service completed their treatment within two hours.
  - 100% of people who attended the service were provided with a complete episode of care within four hours.
- During January 2022 we found that of the 1,393 people who attended the service:
  - 70.8% had their care completed by the service and were discharged.
  - 19.6% were referred to another service which was more appropriate to their needs. For example, for patients who met exclusions for the service and therefore could not be treated, such as babies under six months of age, or pregnant women who presented with pregnancy related problems.
  - 5.8% were referred to the local Emergency Department.
  - 0.8% were referred to ambulatory care services.
  - 0.3% were admitted to hospital.
  - 0.1% were signposted or booked into GP service.
  - 2.6% patients walked out, or the consultation was otherwise cancelled.
- From 2021 to 2022 the provider reported that demand had shown an increase of 49.5% (from 11,049 patient contacts to 17,459 patient contacts). This included both telephone and face to face consultations. Telephone consultations ceased in mid-January 2022, and the service reverted to only carrying out face to face consultations.
- The service made improvements through the use of both clinical and non-clinical audits. We saw that audit processes had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, we saw that audits had been undertaken into medicines management which included prescribing and the use of PGDs. When audits had identified areas of non-compliance then actions were taken to improve performance. Audits were full two-cycle audits where progress could be monitored.
- The service used web-based clinical documentation audit software that automatically extracted a selection of clinical documentation from patient clinical records. This allowed clinical audit facilitators to anonymously audit clinical notes, provide analysis and feedback directly to the clinician, as well as highlighting both good and poor clinical practice/documentation.
- We saw that performance was regularly monitored and reported both via a monthly quality meeting, and to the organisational Board.
- The service's commissioner had undertaken an in-depth engagement exercise with the public and service users between November 2021 to January 2022. This was completed as part of the contract review process for the service, as well as being part of a wider review of urgent and emergency care. The results showed that 41% of respondents who had attended the King Street Health Centre in the previous two years had done so because they had been unable to obtain an appointment from their own GP, whilst 36% attended because it was convenient, and 30% had used the service before and had found it had worked well for them. Overall, 93% of those who had attended the service as part of this engagement activity had rated the service good, very good or excellent.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.

Inspected but not rated

Are services effective?

- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The service provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, we saw from clinical audits that specific instances of non-compliance with operating practices or guidelines had been raised with the staff members concerned.

Coordinating care and treatment

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

- Care and treatment for patients in vulnerable circumstances was coordinated with other services as appropriate.
- Staff communicated promptly with patients' registered GPs so that their GP was aware of the need for further action. A case record was created for each person who attended the service, and this was sent as a post event message to the patient's practice following consultation. There was also the ability to send tasks and actions to a patient's own GP through the electronic clinical system and to add comments to post event messages. For example, "patient presented to the service with concerning symptoms which require your attention".
- 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.
- 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.
- Clinicians were able to make direct referrals to hospital speciality services, but did not have direct access to other hospital services.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this and included advice leaflets. In addition, patients were advised when over-the-counter medication could have met their clinical need.

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.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service. For example, in January 2022 we saw data which showed that 5.8% of people who attended the service had been advised to attend the local emergency department.

Inspected but not rated

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service gave patients timely support and information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. For example, we were told that extended appointments were available for those with complex needs.
- We spoke with two patients on the day of inspection. They told us that that they had been assessed and treated promptly and were very satisfied with the level of care received.
- We saw that the service was responsive to the needs of specific vulnerable groups. For example, following a complaint about gaining access to the walk-in centre via the door intercom, the service had introduced a new procedure which used mobile text messaging to aid access.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.

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. For example, the provider had identified issues including the limited length of the service contract (rolling year on year contract), continuing COVID-19 pressures, and the recruitment and retention of staff. They had devised and implemented measures and plans to meet these challenges. For example, in relation to staff recruitment the provider had introduced an apprenticeship programme to train and develop trainee advanced clinical practitioners (ACPs). The trainees' academic programme was being provided by a local university over a three-year programme of study, and operational experience provided by Local Care Direct Limited. When working at King Street Health Centre the trainees were supported by GP educators and an ACP supervisor, and operated under a comprehensive competency framework.
- Managers worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff informed us that they felt supported, and that relationships were generally good.
- Senior management was accessible throughout the operational period, with an on-call support system that staff were able to use.

Culture

The service had a culture of high-quality sustainable care.

- Managers and staff felt respected, supported and valued. They were proud to work for the service.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff informed us that they were able to raise concerns and were encouraged to do so.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training.

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 joint working arrangements promoted co-ordinated person-centred care. We saw that regular meetings were held to discuss key operational areas. This included monthly clinical governance, senior management, and quality group meetings. Minutes and details of meetings were accessible to staff, and logs on ongoing actions kept.
- Staff were clear on their roles and accountabilities, this included actions in respect of safeguarding and infection prevention and control.
- Managers had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

Inspected but not rated

Are services well-led?

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- There were pathways in place to support vulnerable patient groups such as palliative care patients, patients with mental health issues, children under two years of age, dental patients, and the frail elderly. When required patients were signposted or referred to other more appropriate services. The service monitored vulnerable patients who frequently attended the service.
- 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. Managers had oversight of medicines and patient safety alerts, incidents, and complaints. Senior managers also had a good understanding of service performance against local key performance indicators. Performance was regularly discussed at senior management and Board level. Performance was shared with staff, and with the local CCG as part of contract monitoring arrangements.
- The provider planned the service to meet the needs of the local population. During the COVID-19 pandemic the service had changed the way it operated to meet needs. This included a move towards both telephone/remote consultations as well as face to face consultations. Since then the service had been contractually required to return to the delivery of face to face consultations only. The provider felt that the move back to solely walk in access had removed flexibility for themselves and choice for patients in how the service could be accessed.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of actions to resolve concerns and improve quality. The provider had an audit programme in place, and outcomes were reported to the internal audit and risk committee, with the organisational Board having final oversight.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- The provider had access to a clinical test results system which allowed them to see pathology and radiology results, even when these had been requested by other services such as the presenting patient's own GP.
- Quality and sustainability were discussed in relevant meetings where staff had sufficient access to information. We saw that the provider compiled detailed monthly performance reports which fed into the organisation's clinical governance processes.
- The service used information technology systems to monitor and improve the quality of care. This included use of web-based clinical documentation audit software that automatically extracted a selection of clinical documentations from the patient clinical record for assessment.
- The service submitted data or notifications to external organisations as required.