Bridgewater Community Healthcare NHS Foundation Trust

RY2

Urgent care services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
	Bevan House		

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

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

Where applicable, we have reported on each core service provided by Bridgewater Community Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Bridgewater Community Healthcare NHS Foundation Trust.

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We have judged that overall, the urgent care services provided by Bridgewater community health care NHS foundation trust required improvement because:

- At Leigh WIC the triage system in place did not reflect national guidance and meant that patients were not assessed in a timely manner.
- At St Helens there were delays in triaging patients. However, just over 94% of patients were triaged within an hour.
- There was no electronic paediatric or adults pain scoring system in place which meant that patients' pain was assessed using different systems.
- The service did not have an electronic standardised early warning score system in place, which is not in accordance with best practice.
- Allergies information was not recorded in 33.3% of the records we reviewed.

However

- There was a culture of reporting and learning from incidents.
- Areas we inspected were visibly clean and tidy and staff responsible for cleaning followed protocols which helped control infection.
- Staff followed guidelines and pathways when caring for patients and some local audits were in place.
- Processes were in place to ensure staff maintained competencies at work. These included working through competency checklists, and developing further skills through study.
- Staff worked together locally and within the region to provide care for patients.
- Systems were in place to support children and adults to provide informed consent to procedures.
- Staff were kind and compassionate in their communications with adults, parents and their children. Patients were given information in a way they could understand.
- Staff knew about populations in their local area and the reasons patients came seeking care or treatment.
- Waiting areas catered for the needs of patients, with enough seating, toilets, and hand washing facilities.

Summary of findings

Background to the service

Bridgewater Community Healthcare NHS Foundation Trust provides urgent care services at one walk-in centre in Leigh (WIC), one urgent care centre in Widnes (UCC) and one minor injuries walk-in centre in St Helens (MIWIC). The centres provide urgent care for minor injuries and illnesses for the residents of St Helens, Leigh, Widnes and the surrounding areas. The services are funded by St Helens, Wigan Borough and NHS Halton Clinical Commissioning Groups (CCGs). They are managed and operated by the registered provider Bridgewater Community Healthcare NHS Foundation Trust.

Bridgewater Community Healthcare NHS Foundation Trust employed a walk-in centre clinical manager to oversee the day-to-day running of the three centres. In each walk-in centre there was a clinical services manager who reported to the clinical manager. At St Helens WIC the service employed 33.05 WTE staff members, at Leigh WIC it employed 30.83 WTE staff members and at Widnes UCC it employed 24.73 WTE staff members plus seven administrative staff members. At Widnes UCC the provider funded by the CCG, a GP was on site during opening hours. At Leigh WIC there was an arrangement between North West Ambulance Service NHS Trust and the provider to jointly fund a GP who was based on site seven days a week as part of an admission avoidance programme. At St Helens WIC the service was nurse-led.

From April 2015 – March 2016 St Helens WIC had 64,243 first contact attendances (average 1235 per week), Leigh WIC had 46,261 attendances (average 889 per week) and Widnes UCC had 41,264 attendances (average 793 per week).

Our inspection team

This inspection was undertaken by a CQC inspector and an urgent care centre manager acting in capacity of specialist adviser.

Why we carried out this inspection

We inspected this core service as part of our comprehensive wave 2 pilot community health services inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 31 May and 1 and 2 June 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 16 June 2016.

Summary of findings

What people who use the provider say

'The service saved me a long wait in A&E'.

Good practice

The joint initiative for hospital avoidance between Bridgewater and North West Ambulance Service was the highest performing admission avoidance pathfinder initiative within the North West.

Areas for improvement

Action the provider MUST or SHOULD take to improve

SHOULD

- Ensure all relevant staff have received level three safeguarding training.
- Ensure all staff are up to date with their annual appraisals.
- Ensure all staff record allergy information within patient's records.
- Ensure all staff have completed and are kept updated with their basic resuscitation training.
- Ensure there is a paediatric trained staff member on each shift.
- Ensure there is an appropriate pain assessment tool in place.

MUST

- Ensure that patients are triaged appropriately in line with national guidance. (Reg 12(1))

Bridgewater Community Healthcare NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated this service as requires improvement for safety because:

- At Leigh WIC the triage system in place did not reflect national guidance and meant that patients were not assessed in a timely manner.
- The service did not have a standardised early warning score system in place, which is not in accordance with best practice.
- Allergies information was not recorded in 33.3% of the records we reviewed.
- Mandatory training levels were below the trust's target at Widnes UCC and Leigh WIC.
- At Leigh WIC the second signatory did not individually sign the PGD documentation. This breached the trust's policy and was escalated at the time of our inspection.
- Staff were unaware of the major incident plan in the WICs and UCC.

However,

- There was a good incident reporting culture.
- Staff were aware of the principles of the duty of candour. However, they were not aware of the terminology.
- Medicines were securely stored.
- All three centres were visibly clean and well designed.
- Reception staff were trained in red flag symptoms and knew how to prioritise these patients for medical support.

Safety performance

- The trust board and the clinical manager were provided with an overview dashboard that included performance and safety information including the unplanned re-attendance rate, length of time within the department, time from attendance to treatment and the number of patients who left without being seen.

Incident reporting, learning and improvement

- From April 2015 to March 2016 there were 111 incidents reported across the WICs and UCC. 91% of these incidents were low or no harm incidents. Themes included aggression, capacity and demand issues and treatment delays.
- Incidents were reported electronically. Staff received automatic email receipts following submission.

Requires improvement

Are services safe?

Incidents went from the governance team to be investigated by WIC/UCC managers or senior nurses. Investigation staff created an action plan, which was reviewed at monthly quality meetings.
- Staff that we spoke with told us there was a culture of reporting and learning from incidents amongst their teams.
- Staff told us that learning from incidents was shared at monthly meetings. If an issue was urgent, a mini-meeting would be held for information to be shared.
- The service had one STEIS incident (a serious incident) in January 2016. We reviewed the incident investigation. This incident was appropriately investigated and lessons learnt were shared with staff members across all the centres. Actions to prevent recurrence were also in place at the time of our inspection.

Duty of Candour

- The duty of candour is a legal duty to inform and apologise to patients if mistakes in care have led to moderate or significant harm. We saw examples of duty of candour being implemented when required. Senior nursing staff were aware of the principles of the duty of candour. However, they did not know the terminology.

Safeguarding

- The intercollegiate document on safeguarding recommends that all clinical staff working with children, young people and/or their parents/carers should be level 3 trained. Children were seen in all three centres. 100% of staff at Widnes UCC had completed their children's level 3 training. At Leigh WIC 92.8% of staff had completed the children's level 3 training. At St Helens 90% of staff had completed the children's level 3 training. At Leigh and St Helens the number of trained staff was not in accordance with national guidance. However, all staff had completed level 2 children's and adults' safeguarding training.
- The service had a safeguarding policy and staff were aware of their roles and responsibilities regarding safeguarding.
- A band 5 nurse reviewed the attendance of children within the department to ensure no one left the department without being seen. If children left the centre without treatment, the band 5 would ensure they had received treatment elsewhere.

Medicines

- Medicines were securely stored at all three centres. They were kept in well-organised rooms with appropriate records available.
- Secure systems were in place for prescription pads and staff were aware of the policy regarding their usage.
- The service had five nurse prescribers at Leigh WIC. At Widnes UCC there were 11 nurse prescribers. At St Helens there were 14 nurse prescribers.
- PGDs were in place at all centres and were available electronically and on paper in case the electronic system went down.
- Most PGD documentation was appropriately completed. However, at Leigh WIC we identified an issue with block signing of the PGD documentation. This issue was immediately escalated to the service manager.
- Nurse prescribers completed an annual update course and attended monthly prescriber meetings. The prescribers at Leigh and Widnes also worked alongside a GP.
- The service had safe systems in place to manage prescription pads.
- Shift co-ordinators completed prescriptions for agency staff.
- In 33.3% records we reviewed allergies were not documented.

Environment and equipment

- The centres were all appropriately designed and provided ground floor access to the service.
- Each of the consulting rooms had a diagnostics box containing equipment that the clinicians may require during consultations with patients.
- Equipment we reviewed was PAT tested and had had recent maintenance reviews.
- Arrangements were in place for the management of waste and clinical specimens were appropriately labelled.
- There was adequate seating space in the waiting areas. All reception areas were located close to waiting areas so patients could be seated whilst waiting to speak to reception staff.
- Defibrillators were available at each site.

Requires improvement

Are services safe?

- The service had resus trolleys that were fully equipped, the contents were all in date and regular checks were documented at the time of our inspection. At Leigh WIC the resus trolley was particularly well organised to facilitate rapid access to equipment.
- All reception staff were aware of the location of emergency equipment.

Quality of records

- The service used electronic records. The system the service used could also provide staff with some patients GP records if the patient's GP was using the same system.
- At Leigh WIC we reviewed eight sets of records. All records evidenced time of patient arrival, time of initial triage and denoted the name and grade of the doctor/ nurse reviewing the patients. In all the records we reviewed the patients were not triaged within 15 minutes of arrival. In two out of eight of the records we reviewed the patients were not seen within an hour, either for triage or assessment. Allergies were not documented in four out of eight sets of records.
- At St Helens WIC we reviewed 10 patients medical records. All patients were triaged in line with national guidance. All records evidenced time of patient arrival, time of initial triage and denoted the name and grade of the doctor/nurse reviewing the patients. However, in two out of ten records allergies were not documented.
- Monthly records audits were undertaken and staff were given feedback on a 1:1 basis. However, the sample size (five) did not seem proportionate to the number of episodes of care the service provided.

Cleanliness, infection control and hygiene

- At Widnes UCC infection control data did not give an overall compliance percentage. An action plan was identified and actions were completed at the time of our inspection.
- At Leigh WIC infection control audits showed 97% overall compliance with the trust's infection prevention and control policy. Staff were 100% compliant with the hand hygiene policy.
- At St Helens WIC infection control audits showed 81% overall compliance with the trust's infection prevention and control policy. Staff were 83% compliant with the hand hygiene policy. An action plan to address issues was put in place and these actions were complete at the time of our inspection.
- All areas we visited were visibly clean.
- During our inspection, we observed staff using appropriate hand washing techniques prior to and after their treatment of patients.

Mandatory training

- Staff told us that they received annual online mandatory training. We requested data from the trust that showed at Widnes UCC 73% of staff had completed their training. At Leigh WIC 91% of staff had completed their mandatory training. These figures were below the trust's target of 95%. However, 100% of staff at St Helens had completed their mandatory training.
- 41% of staff had completed moving and handling training. 31.6% of staff had completed prevent training. 36.8% of staff had completed dementia awareness training. 45.5% of staff had completed conflict resolution training. These figures were all below the trust's target of 95%.

Assessing and responding to patient risk

- National guidance requires that UCCs and WICs triage patients within 15 minutes if they are children or 20 minutes if they are adults. At Leigh WIC a decision had been taken for triage to be stopped and for patients to be treated on their first contact with a clinician, unless they had been waiting for an hour or more. When patients had been waiting an hour or more, band 5 nurses reviewed them and completed initial observations and a triage assessment. This represented a patient safety risk and was escalated to the service manager at the time of our inspection. On our unannounced visit this practice was still continuing. We reviewed the computer system, which showed that three patients had not been seen within one hour including one two year old, an 18 year old and a 25 year old. There was also one patient who had been waiting for 18 minutes with shortness of breath.
- We asked the trust to confirm how many children were triaged within 15 minutes throughout May 2016. The trust advised at Leigh WIC out of 1142 children, 921 children were not triaged within 15 minutes (80.6%). 63.7% of these patients were not triaged within 30 minutes. 40.2% of these patients had not been triaged within an hour.

Requires improvement

Are services safe?

- We asked the trust to confirm how many adults were not triaged within 20 minutes. At Leigh WIC out of 2738, 2195 were triaged after 20 minutes (80.2%). 74.9% of the adult patients had not been triaged within 30 minutes and 53.3% had not been triaged within one hour.
- At St Helens WIC out of 1654 children, 80.4% of children were not triaged within 15 minutes. 44.5% of children were not triaged within 30 minutes. 5.3% of patients were not triaged within an hour.
- At St Helens WIC out of 3794 adult patients, 63.3% were not triaged within 20 minutes. 39.5% of patients were not triaged within 30 minutes. 4.9% were not triaged within one hour.
- At Widnes UCC out of 1352 children, 13.6% were not triaged within 15 minutes. 1% were triaged after 30 minutes and no children waited over an hour to be triaged. Out of 2495 adult patients, 4.2% were triaged outside 20 minutes. 1% of patients were not triaged within 30 minutes and 0.1% were not triaged within an hour. We escalated our concerns to the trust who took immediate action.
- All staff told us there was no formalised early warning assessment system within the service. Staff told us that early warning scores assessments were not completed on each patient. Staff decided when completion of early warning scores should be completed depending on the patient's presenting complaint. This information was recorded within the general notes, which meant it was not consistently located.
- At all three centres staff prioritised patients as non-urgent, standard, urgent, very urgent and immediate resuscitation
- The service told us that for resuscitation training, 62.1% of staff were up to date with their training. This is not in line with best practice outlined in the College of Emergency Care guidance 'Unscheduled Care Facilities' which requires all staff to have Immediate Life Support (ILS), Paediatric Life Support (PLS), Paediatric Immediate Life Support (PILS) and primary survey assessment competencies. However, there were no reported incidents outlining patient harm because of the levels of resuscitation training.
- Sepsis screening guides were available in each examination room we visited.
- Reception staff were trained to be aware of "red flag" presenting complaints (for example chest pain and shortness of breath).

Staffing levels and caseload

- At the time of our inspection, the trust reported that at Widnes UCC there were 26.7% nursing vacancies due to service expansion. Senior staff were working additional clinical shifts and the service were using bank and agency staff and some worked long days to maintain the minimum required staffing levels. Recruitment had been undertaken and new starters were reported to be starting in July 2016 to fulfil the staffing shortfall.
- At Widnes GPs were all agency staff and some worked long days 8am to 10pm. Consideration was being given to longer-term position at the time of our inspection.
- Senior nursing staff had responsibility for different core areas e.g. induction and training, medications management, students, safeguarding and mental health.
- Reception staff told us they frequently worked on their own when there should be two members of staff on duty. We reviewed the standard operating procedure for reception staff and this stated that there should be a minimum of one member of staff at all times but preferably two or three at different points during the week. No incidents were reported to have occurred due to there only being one member of staff on reception.

Managing anticipated risks

- Reception staff were aware of red flag conditions for example chest pain. If patients presented with these complaints, they were taken straight through to the treatment area to be seen by a nurse.
- Reception staff were trained how to put patients on the system requiring priority assessment if a patient's needs required it.

Major incident awareness and training

- Staff in the centres were unaware of the major incident plan and the location of any documentation to help them. We reviewed the trust's intranet and found a major incident policy that was over one hundred pages long, generic and did not specify specific actions for the centres. We escalated our concerns to the clinical manager at the time of our inspection.

Requires improvement

Are services effective?

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

Summary

We rated this service as requires improvement for being effective because:

- There was not a consistent electronic pain scoring system in place to for staff to use to assess patient's pain levels. This is not in accordance with national guidance.
- The triage system at Leigh WIC was an 'assess and treat system' which did not follow national guidance for effective triage in an urgent care setting.
- 62.1% of staff were up to date with their resuscitation training. This did not meet the requirements set out in national guidance or the trust's own target of 95%.
- The number of local record keeping audits completed was low and did not reflect an appropriate percentage of records reviewed given the number of episodes of care provided.

However:

- Staff followed guidelines and pathways when caring for patients and some local record keeping audits were in place.
- Processes were in place to ensure staff maintained competencies at work. These included working through competency checklists, and developing further skills through study.
- Staff worked together locally and within the region to provide care for patients.
- Staff were able to access the information they required to provide good care such as x-ray images, advice or information.

Evidence based care and treatment

- At Widnes UCC staff had collaborated with local hospitals to create pathways to manage patients' conditions.
- The service used the Manchester triage system, a clinical risk management tool used by clinicians in Emergency Departments worldwide to enable them to safely manage patient flow when clinical need exceeds capacity.
- Policies and procedures were all up to date and available on the trust's intranet.
- Staff followed guidelines issued by the National Institute of Health and Care Excellence (NICE) (such as head or neck injury guidelines). Guidelines were accessible on the trust intranet with paper copies in folders.
- Some local audits were completed to ensure pathways were followed correctly. For example the service undertook a quarterly antibiotic audit to ensure antibiotics were being used and issued appropriately in accordance with Pan Mersey Area Prescribing Committee formulary and National Institute of Health and Care Excellence.
- At Widnes UCC and St Helens WIC there was a triage system in place that reflected national guidance. At Leigh WIC triage procedures were not in accordance with national guidance, as outlined above. At all three centres we observed care provision. Patients were appropriately assessed, diagnosed and treated in accordance with national guidance and best practice.
- Each centre's nursing leads reviewed a selection of their team's records on a monthly basis to ensure that care provided was in accordance with best practice and national guidance.
- Records we reviewed showed appropriate plans of care and reflected the assessments we observed.
- The service arranged diagnostics e.g. x-ray, ultrasound and d-dimer testing (deep vein thrombosis screening) and had arrangements in place to ensure that the results were reviewed by a clinician and, where necessary, acted upon.
- To ensure continuity of care patients were referred back to their registered GP, once their urgent care needs had been met.

Pain relief

- During our inspection, we found no evidence of a pain assessment tool and staff told us they used the tool they had previously used in their former roles. This meant different assessment criteria was being used by different staff members. This is not in accordance with the Standards for Children and Young People in Emergency Care Settings 2012.

Requires improvement

Are services effective?

- Pain scores were not consistently documented in medical records. Senior staff within each WIC/UCC were aware of this but we found no evidence that this issue had been addressed. We escalated our concerns regarding these issues at the time of our inspection.

Patient outcomes

- Information about the outcomes of patients' care and treatment was routinely collected and monitored by service managers and the clinical services manager. The data from the three centres were compared and analysed to ensure any reasons for variances were clearly understood and acted upon.
- The service monitored unplanned attendance and compared this data with other centres within the service but also with national targets.
- The trust also monitored how many patients unexpectedly re-attended the centres within seven days of discharge. It is good practice for less than 5% of patients to re-attend. At Bridgewater, the re-attendance rates were below national average at 0.43% (Leigh WIC), 0.02% (St Helens) and 0.08% (Widnes UCC).

Competent staff

- New nursing and medical staff underwent a trust induction. Local induction also took place and we saw checklists used to ensure appropriate details were provided for bank, agency or new staff.
- New staff followed an induction programme which included enrolment on the service's minor illness and ailments course which is accredited by Chester University.
- Staff within the service who were above band 5 were IRMER trained able to read x-rays.
- The GPs within the service acted as mentors for nurse prescribers.
- Staff told us that they received supervision. However, this was not documented.
- Senior staff had completed the trust's leadership training.
- Staff received annual appraisals via their line manager.
- The service told us that for resuscitation training, 62.1% of staff were up to date with their training. This is not in line with best practice outlined in the College of Emergency Care guidance 'Unscheduled Care Facilities' which requires all staff to have Immediate Life Support (ILS), Paediatric Life Support (PLS), Paediatric Immediate Life Support (PILS) and primary survey assessment competencies. However, there were no reported incidents outlining patient harm as a result of the levels of resuscitation training.

Multi-disciplinary working and coordinated care pathways

- Staff worked well together to provide care for patients. For example, staff within the service worked closely with GPs and could request chest x-rays via them.
- Staff had good working relationships with x-ray, ultrasound and wound clinics.
- WIC and UCC centre managers worked closely together.
- Leigh WIC worked closely with North West Ambulance Service on an admission avoidance 'pathfinder' service which achieved 92.6% deflection from the local A&E.

Referral, transfer, discharge and transition

- Staff ensured that patients who were referred to hospital were offered suitable transportation.
- The service ensured that a nurse followed up all paediatric referrals to the hospital.
- The online record system sent immediate updates to GPs who were on the system. Electronic notifications were sent to other GP practices.
- If patients sustained a minor fracture they were initially treated within the centre then referred on to the fracture clinic.

Access to information

- Staff reported that they had good system access and that patient records were available. If the system went down the service had good back up plans in place. The records completed during any down time were also added to the electronic system when it next came online.
- Discharge summaries were provided to GPs once a patient's treatment was completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that they had completed online training for dementia and mental health.
- The service had a nurse with good understanding of mental health and who knew who to signpost patients to for further assistance. The nurse attended link meetings for all the centres to keep staff updated.

Requires improvement

Are services effective?

- All staff we spoke with were aware of Gillick competence and Fraser guidelines.

Good

Are services caring?

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

Summary

We rated this service as good for being caring because:

- We observed compassionate care being provided by staff who engaged with adults and children to ensure they were happy whilst care was in progress.
- We spoke to people who said they were happy with the care provided, and that care was fully explained in a way they could understand.
- Staff communicated with people so that they understood their care, treatment or condition. We observed staff adapting their communication style for different ages of patient.

Compassionate care

- We spoke to seven families at the centres. All of them were happy with the care provided.
- Staff understood and respected people's personal, cultural, social and religious needs, and took these into account when treating patients.
- Care was compassionate and staff quickly gained good rapport with patients.
- In the episodes of care we observed, staff showed an encouraging, sensitive and supportive attitude to patients and those close to them.
- We observed staff treating patients with compassion and engaging with them to make the process of obtaining clinical observations as easy as possible. We saw one example where a nurse took the time to interact with a young child and family members, gaining trust and cooperation through engagement and play.
- During our inspection staff ensured that people's privacy and dignity was always respected. Treatment was provided in rooms with solid doors. However, conversations at reception could be overheard. Reception staff tried to overcome this by offering patients the option of going to a more private area.

Understanding and involvement of patients and those close to them

- Staff communicated with people so that they understood their care, treatment or condition. We observed staff adapting their communication style for different ages of patient. For example one young patient had additional needs and the nurse treating him responded compassionately distracting him whilst his laceration was treated which helped him remain calm.
- All the patients and carers we spoke with felt that staff communicated well with them, ensuring they were fully informed about their medical condition and what care or treatment was required.
- Patients told us that staff had responded in good time to their needs.

Emotional support

- We observed staff showing their understanding of the impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- We observed staff providing reassurance and comfort to patients and their relatives.

Good

Are services responsive to people's needs?

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

Summary

Overall, we rated responsive as good. This is because:

- Staff knew about populations in their local area and the reasons patients came seeking care or treatment.
- Waiting areas catered for the needs of patients, with enough seating, toilets, and hand washing facilities.
- Translation was available for patients whose first language was not English.
- Wait times were not excessive and department of health targets were being met.
- Low levels of complaints were received and learning was disseminated to staff following investigation.

However,

- Triage times did not meet the requirements set out in national guidance.

Planning and delivering services which meet people's needs

- Services were planned around the needs of local people. Commissioners worked closely with the three centres to help develop the services to meet patients' needs for example at Leigh WIC the CCG worked closely with North West Ambulance Service and the trust to develop the 'pathfinder service', an admission avoidance service.
- There was enough seating for patients in the waiting areas. Whilst these were in close proximity to reception areas (which could affect privacy for patients), we saw signs for visitors prompting them to inform staff if they would like to provide details in a more private setting.
- Waiting areas had toys for children to play with.
- Toilets and hand sanitising facilities were available throughout all three departments.

Equality and diversity

- Staff told us that they had access to a telephone translation service.
- Disabled patients had access to all treatment areas.
- Staff were familiar with the needs of patients with learning disabilities, or complex needs. They explained that patients usually arrived with carers who could explain their needs.
- Advice leaflets were only available in English, which did not reflect the diversity of local service users.

Meeting the needs of people in vulnerable circumstances

- The trust-wide safeguarding team provided support for patients with dementia and learning disabilities.
- The service offered facilities for breast feeding mothers.

Access to the right care at the right time

- The Department of Health target for urgent and emergency services is to admit, transfer or discharge 95% of patients within four hours of arrival. At Leigh WIC on average patients waited 54 minutes from arrival to treatment. 95% of patients waited under 218 minutes from arrival until departure. At Widnes UCC 95% of patients waited under 195 minutes from arrival until departure. At St Helens WIC 95% of patients waited under 165 minutes from arrival until departure. These figures were all above the Department of Health target.
- We reviewed the number of breaches of the four-hour target set by Department of Health target in April 2016. At Leigh WIC there were 17 breaches, at St Helens there were 10 breaches and at Widnes there were 37 breaches. The trust were sited on this and staff told us they had plans in place to address this.
- At Leigh WIC 4.2% of patients left without being seen. At Widnes UCC 0.09% of patients left without being seen. At St Helens WIC 0.9% of patients left without being seen.
- Triage times across the service were outside the requirements set out in national guidance.
- At Widnes UCC the service had pathways in place to manage adults and children's care.
- At Leigh WIC the service runs a pathfinder service with North West Ambulance Services. This service works to prevent hospital admissions. From April 2015 – March 2016 the service saw 1246 patients. 97% of these patients were successfully treated without needing a hospital admission.

Good

Are services responsive to people's needs?

- At Leigh WIC staff expressed concern about the length of time it took to receive blood test results. Blood samples were sent to Salford. Staff explained that results would only be available at 11pm to 12am for further action. Staff told us managers were aware of this situation.

Learning from complaints and concerns

- Staff explained the process for managing complaints. If explanation at the time did not resolve the issue, staff referred complainants to the trust patient advice and liaison service (PALS). Leaflets were available explaining the process.
- Complaints were discussed during staff meetings or individually with the staff involved. Learning was shared following complaints.

Good

Are services well-led?

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

Summary

Overall, we rated well-led as good. This is because:

- Each team across the service had weekly and monthly meetings to review incidents, performance issues and planning, amongst other topics.
- Each clinical services manager across the trust had their own strategy for their service which team members were aware of.
- Staff had visions about the future and how services would be improved for patients.
- Work had been done to strengthen governance and regular governance meetings took place.
- Risk registers were in place and captured the concerns described by senior managers during our inspection.
- Staff told us they felt happy to work for the trust and proud of the teams they worked with.

Service vision and strategy

- Staff told us that they were aware of the services vision and strategy.
- Vision and values for the trust were displayed on posters in each area we visited. Staff were also aware and understood what these were.
- Each clinical services manager across the trust had their own strategy for their service which team members were aware of.
- Staff had visions about the future and how services would be improved for patients.

Governance, risk management and quality measurement

- The service had monthly governance meetings. Staff felt able to raise issues at governance meetings. The agenda was placed on the wall before a meeting and staff could add any concerns to it. Further meetings were held between the clinical services manager and the clinical managers on a monthly basis.
- Risk registers were in place and captured the concerns described by senior managers during our inspection.
- The clinical manager produced monthly performance reports and fed into the trust-wide governance system.
- Each local team had their own local risk register. Risk registers were maintained on the electronic system and reviewed and updated at least monthly by the clinical manager and clinical services managers.

Leadership of this service

- A Walk-in centre clinical manager oversaw the day to day running of the three centres.
- In each centre there was a manager who reported to the clinical manager.
- Staff understood the reporting structure and told us that the support from managers was good.

Culture within this service

- Staff told us that they worked in a positive environment where there was a good team spirit. Staff appreciated the range of backgrounds nurses had within the service and explained that they regularly sought second opinions and advice from one another.
- Staff told us that service leaders were visible within the service.

Public engagement

- Friends and family surveys were undertaken in all three centres. Feedback was positive across the service. At Widnes UCC 95.2% of patients would recommend the service, at Leigh WIC 96.4% of patients would recommend the service and at St Helens 96.4% patients would recommend the service.

Staff engagement

- The Staff Friends and Family Test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. Staff were asked whether they would recommend their service as a place to receive care. The trust scored above the England average for staff who would recommend the trust as a place to receive care with 85% compared to an England average of 79%, whilst also scoring lower than average for the percent who would not recommend. However the response rate was 6% lower than the England average.

Good

Are services well-led?

- The trust scored 20% below the England average with 42% of staff recommending the trust as a place to work whilst 37% would not recommend, when compared to an England average of 19%. However, all staff we spoke to stated they would recommend the trust as a place to work.
- Staff engagement occurred through meetings and trust-wide blogs.

Innovation, improvement and sustainability

- The service were considering extending their hours at the time of our inspection. An options paper was with the finance team at the time of our inspection.
- At St Helens WIC the service offer a minor injury and ailments course in conjunction with Chester University.
- The service had a rolling programme in place for nurse prescribers.
- At St Helens WIC and Widnes UCC the service had a prophylaxis treatment pathway for prevention of deep vein thrombosis below the knee.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (a) HSCA 2014 (Regulated Activities) states:** **Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—** 1. assessing the risks to the health and safety of service users of receiving the care or treatment; **How the regulation was not being met: People who use services and others were not protected against the risks associated with unsuitable triage procedures. Regulation 12 (2) (a).**

This section is primarily information for the provider

Enforcement actions

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.