# Sheffield City GP Health 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 safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires improvement |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Sheffield City GP Health Centre on the 18 and 25 January 2017. Overall, the service is rated as good. Our key findings across all the areas we inspected were as follows:

- The service had a number of policies and procedures to govern activity, and managers told us all staff, including locums, had access to policies and procedures on the providers group intranet. However we found examples where staff had not always followed the guidelines. For example, referring to the local child services team when referring to other agencies such as the police.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses with the exception of a significant event form was not always completed when reporting adult safeguarding concerns as per the adult safeguarding policy
- There was a system in place for learning from significant events.
- Some lessons were shared to make sure action was taken to improve safety in the service.
- Risks to patients were assessed and managed, with the exception of those relating to fire safety. A fire risk assessment was completed two days prior to our inspection and action was taken by the provider following the risk assessment to address the issues. However these issues should have been dealt with more proactively and been under regular review.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Audits and reviews demonstrated quality improvement.
- Patients said staff treated with them with respect.
- Information about 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.
- There was a leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvement are:

# Summary of findings

- The provider must ensure the governance systems and processes are implemented and monitored to ensure compliance with the regulations.

The areas where the provider should make improvement are:

- The provider should review the initial form and checklist patients complete so that it is available in large print and other languages for use when using the telephone interpretation service. The provider should keep a record of nurses' competencies to see and treat children.
- The provider should have written reference to the Duty of Candour within their policies.

**Professor Steve Field CBE FRCP FFPH FRCGP**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The service is rated as good for providing safe services.

- The service had a number of policies and procedures to govern activity, and managers told us all staff, including locums, had access to policies and procedures on the providers group intranet. However we found examples where staff had not always followed the guidelines. For example, referring to the local child services team when referring to other agencies such as the police.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses with the exception of a significant event form was not always completed when reporting adult safeguarding concerns as per the adult safeguarding policy
- There was a system in place for recording, reporting and learning from significant events.
- Lessons were shared to make sure action was taken to improve safety in the service.
- The service had adequate arrangements in place to respond to emergencies and major incidents.
- Arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security, and disposal).

**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.
- Internal audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Clinicians provided care to walk-in patients based on current evidence based guidance and their skill competencies. For example the doctor would treat all children under one and pregnant women.
- There was evidence of appraisals and personal development plans for all staff. One member of clinical staff reported that they had not had any clinical or management supervision for over a year.

# Summary of findings

- The provider reviewed the triage system to ensure staff saw patients within an acceptable time for their illness and the patient's waiting time was monitored. However, the initial patient assessment checklist completed by the patient on entering the centre was only available in English and in small print.

**Are services caring?**

Good

The service is rated as good for providing caring services.

- Feedback from the large majority of patients through our comment cards and collected by the provider was positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible but not always available in different languages.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

Good

The service is rated as good for providing responsive services.

- The service had good general facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised.
- The provider had collated information, which demonstrated that patients often had to wait over 60 minutes. In response, the provider had reviewed the triage system and was in the process of recruiting new staff. In addition, as per the escalation procedure, staff raised an incident form if the wait was over four hours.
- During periods of increased demand, staff followed an escalation procedure that liaised with other agencies such as the local ambulance services and hospitals. The service also received briefings from other agencies in times of exceptional demand.

**Are services well-led?**

Requires improvement

The service is rated as requires improvement for being well-led.

- Managers told us all staff, including locums, had access to policies and procedures on the providers group intranet. We

# Summary of findings

found they were not always consistently followed. For example, staff had not always followed the safeguarding tool kit by referring to the local child services team when referring to other agencies such as the police. A significant event form was not always completed when reporting adult safeguarding concerns as per the adult safeguarding policy.

- Risks to patients were assessed and managed, with the exception of those relating to fire safety. A fire risk assessment was completed two days prior to our inspection and action was taken by the provider following the risk assessment to address the issues. However these issues should have been dealt with more proactively and been under regular review.
- The provider had embedded the principle of a duty of candour in their complaints and significant events system. However, they did not have a specific policy to instruct staff.
- The service had a vision and strategy to deliver quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a leadership structure and staff felt supported by management. The service held regular governance meetings.
- The service proactively sought feedback from staff and patients, which it acted upon.

# Summary of findings

## What people who use the service say

We looked at various sources of feedback received from patients about the service.

We received 18 patient Care Quality Commission comment cards, all were positive about the service. Patients said they felt the service offered was good or excellent and staff were helpful, caring and treated them with dignity and respect. The comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the provider's own survey carried out for December 2016 showed from the 76 patients surveyed, 63 were extremely likely or likely to use the service again and only one would not use the service again.

We spoke with six patients during our inspection who told us that staff treated them with care and respect.

In addition, the centre had a patient question of the month. Where patients for one month were asked to drop a green coin in a box to indicate whether they agreed or disagreed with a specific question. For example, staff asked patients would you want WIFI in the building. 20 patients responded and 13 said yes.

In the waiting room the centre had a 'you said and we did' board. The three points the patients raised were long waiting times, toys were needed for the waiting room and improved customer services. For each point, the staff had provided an explanation of what actions the centre had taken and whether this had led to improvements.

# Sheffield City GP Health 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 and two CQC inspectors.

## Background to Sheffield City GP Health Centre

Sheffield City GP Health Centre provides a nurse led, GP supported walk in, see and treat service for the population of Sheffield. The service is also available for patients who work or are passing through the Sheffield area and are registered with a GP service elsewhere. It is commissioned by Sheffield Clinical Commissioning Group (CCG) and Sheffield Teaching Hospitals Trust.

The service is one of 11 GP practices and urgent care centres managed and operated by One Medicare Ltd. The provider's head office operates strategic systems for governance that were cascaded to the individual centre's they provided care from.

Staff at the centre provide advice and treatment for most common illnesses that are urgent but not life threatening. For example, persistent coughs, severe sore throats, rashes, infections and sudden worsening of long term conditions. They cannot help patients that have injuries that may require X Ray, long standing medical conditions that are managed by their own GP, sick notes and repeat prescriptions.

The service is open every day from 8.00am to 10.00pm, 365 days a year.

The premises are accessible and have assisted access toilets. Facilities are available for people with hearing difficulties.

The permanent staff at the centre are two GPs one male and one female. A Lead Nurse, seven nurse practitioners (all female), a business manager, an office manager and a team of receptionists. Locum GPs and advanced nurse practitioner's also worked at the centre.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 18 January 2017 and 25 January 2017. During our visit we:

# Detailed findings

- Spoke with a range of staff (Chief executive, lead GP for urgent care, lead nurse, the local lead doctor, two business managers, two nurse practitioners, and two receptionists) and spoke with six patients who used the service.
- Observed interactions with patients who were being cared for.
- Inspected the premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

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 safe?

## Our findings

### Safe track record and learning

There was a system in place for reporting and recording significant events.

- The centre had a significant event protocol for staff to follow. Staff completed an incident recording form available on the service's computer system. Staff said they graded the severity of the incidents and the computer system sent the incident form to the manager. Any graded a high risk also went to the Chief Executive. We saw evidence that when things went wrong with care and treatment, staff informed patients of the incident. Patients received support; and an explanation based on facts, and an apology where appropriate. Also, the patient was told about any actions taken by the provider to improve processes to prevent the same thing happening again.
- Staff discussed incidents and lessons learned at the daily huddle meeting, monthly centre meetings and at regional management meetings. We saw evidence that staff took action to improve safety in the service. For example, following two patients waiting for over two hours to be assessed, the centre reviewed the process for the initial assessment of patients on arrival and planned to implement a new triage system.
- We reviewed safety records and patient safety alerts. The lead nurse received all of the patient safety alerts and cascaded these to the staff. Staff signed to confirm they had read them; In addition, staff discussed patient safety alerts and incident reports at the daily huddle meetings.

### Overview of safety systems and processes

- The service had systems, processes, and services in place to keep patients safe and safeguarded from abuse, which included:
- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected some of the relevant legislation and local requirements. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all staff had received training on safeguarding children and vulnerable adults. GPs and nurse practitioners were trained to child safeguarding level three. Policies were accessible to all staff. The provider had developed corporate policies for their services and a specific safeguarding tool kit for the walk in centre. If there was a safeguarding concern, the tool kit instructed staff to make a referral to the local authority child or adult safeguarding team.
- However, we found that staff were not following the safeguarding tool kit. For example when we visited the centre on 18th January 2017 we found that staff had raised one child safeguarding concern with other agencies but had not reported to the local authority safeguarding team. In addition, the site GP lead for safeguarding told us that they only made referrals to the local safeguarding team when a patient did not have a GP. Information provided by the provider also showed that out of seven safeguarding concerns staff had referred only one to the local authority safeguarding team. Staff had referred the other safeguarding concerns to the patients' GPs and other health care professionals.
- Other examples of where staff had not followed the safeguarding policies were, the provider's vulnerable adult safeguarding policy stated that 'any requirement to escalate a safeguarding concern should be considered a significant event and logged on the incident reporting system'. However, we found staff had not followed the adult policy. In addition, the children's safeguarding policy recommended that a key task for the safeguarding lead was to provide staff with safeguarding supervision or hold a monthly safeguarding support session. However, we found that this was not taking place at the first visit. On our second visit we noted that one member of staff had been offered safeguarding supervision.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on a official list of people barred from working in roles where they may have contact with children or vulnerable adults.)
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection prevention and control lead. There was an infection control protocol in place and staff had received up to date training. The provider carried out annual infection control audits.

Good

# Are services safe?

- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance. For example, annual servicing of medicine fridges including calibration where relevant.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring service.
- In 2016, the service used 5019 locum hours. Wherever possible regular GP and advanced nurse practitioner locums were used. There was a locum introduction pack and locums were sourced through an accredited NHS provider agency who carried out appropriate recruitment checks.
- At the time of the inspection two nurse practitioners and an emergency care practitioner had been recruited and were waiting to commence employment.

## Medicines Management

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security, and disposal). The service carried out quarterly medicines audits, with the support of the local Clinical Commissioning Group (CCG) medicines management team to monitor prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Four of the nurses had qualified as independent prescribers and could therefore prescribe medicines. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the centre to allow nurses to supply and administer medicines in line with legislation. Staff followed a local protocol to supply medicines that were available over the counter without a prescription, such as Paracetamol or Ibuprofen.
- Staff had processes in place for stock rotation and checking medicines were within expiry dates.
- The service did not hold controlled drugs on the premises.

## Monitoring risks to patients

Some risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in areas accessible to all staff that identified local health and safety representatives. A fire risk assessment of the premises was completed in January 2017. This identified that fire drill records, fire marshal training, fire alarm servicing, and emergency lighting records checks were not in place or recorded. At the time of the inspection, the business manager had arranged for fire marshals to attend training and a programme of fire drills had been documented.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment checked to ensure it was working properly. Clinical equipment was calibrated according to the manufacturer's guidance. The service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella. (Legionella is a term for a bacterium which can contaminate water systems in buildings). Following a legionella risk assessment in January 2017 staff had implemented an action plan to meet the recommendations which included the regular flushing of taps and cleaning of shower heads.
- The managers said they tried to ensure that there were a minimum of three clinical staff on duty. This was normally a triage nurse, a nurse practitioner and a doctor. The centre regularly reviewed historic patient demand and took account of summer and winter pressures when planning minimum staffing requirements. The on-site management team were able to escalate any staffing challenges to the provider using the incident reporting system. The provider used locum and bank staff to cover the service.

## Arrangements to deal with emergencies and major incidents

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

- There was an effective system to alert staff to any emergency.
- All staff received annual basic life support training.
- The service had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.

Good

# Are services safe?

- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### 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 centre monitored that staff followed these guidelines through risk assessments, audits, and checks of patient records.
- Staff attended regular training, which supported their knowledge about changes and updates to guidelines.
- The daily 'huddle' session provided an opportunity for staff to discuss changes to guidelines and the staff kept records of the daily huddle meetings for reference.

On arrival at the centre, patients completed a form that asked the patient their personal details and had a checklist to complete about the reason for their visit to the centre. Those patients whose symptoms the staff and centre were not equipped to treat were given advice about where to go or in an emergency staff called 999. However, the patient checklist was only available in English and in small print.If prioritised as urgent the patient's symptoms would be assessed by a triage nurse within 15 minutes of their arrival at the centre. The triage nurse determined the priority to see a doctor or nurse practitioner.

For those patients who were not triaged a nurse practitioner or a doctor would see them in order of arrival at the centre. Following two significant events where it was thought patients should have been seen sooner, managers had reviewed the triage system and were in the process of implementing a system to ensure all patients were promptly triaged when they attended the centre. The provider aimed to have this new system in place by 19 February 2017.

All patients had initial observations taken by the clinicians dependent on their presenting issue. This included a recording of a patient's pulse rate, temperature, blood pressure, heart rate, respiration rate, oxygen saturation level and their responsiveness level. The observations did not include an assessment tool for pain, as The Cores Standards for Pain Management Services in the UK recommends. However, staff told us the new triage system included a pain assessment tool.

To ensure that staff had the necessary skills to assess and treat the patients, a doctor always saw any child under the age of one or women whose symptoms were related to pregnancy. The permanent nurse practitioners working in the walk in centre did not have paediatric training but said they would work within their competencies and refer the patient to the doctor or children's accident and emergency unit if they felt it was outside their competency level.The Royal College of Nursing Maximising Nursing Skills in Caring for Children in Emergency Departments March 2010 recommend registered adult nurses require additional education and experience to be competent in; safeguarding (including child protection) issues, communicating effectively with children of all ages and their parents / carers, understanding the child's welfare as part of a family unit, pain management and recognition of the sick child.

The provider's paediatric consultation policy, listed the required competencies the staff should have and stated these should be in the centre's staff skill matrix. The managers provided evidence that the provider had held a training day that included a talk by an emergency department children's consultant on spotting the sick child.

### Management, monitoring and improving outcomes for people

The service produced monthly monitoring reports of the activity undertaken and service delivered, which were shared with the Clinical Commissioning Group (CCG) who had agreed key performance indicators. These included reviews of the targets agreed with the CCG and Sheffield Teaching Hospital.Agreed targets were:-

- The clinical consultation starts within 60 minutes of patient booking in. In August 2016, the centre achieved 75%, but this fell to 50% in December 2016, the expected target was 95%. In response the managers monitored patient waiting times. They had reviewed the triage system and planned to implement a new triage system in February 2017, so that the triage nurse saw

Good

# Are services effective?

## (for example, treatment is effective)

everyone who accessed the service. The provider had recruited two additional nurse practitioners and an emergency care practitioner to improve performance against this target.

- The percentage of attendances at the centre, where staff transferred or discharged patients within 4 hours of their arrival at the centre. From July 2016 to December 2016, the centre achieved from 99% to 100%. The expected target was 95%.
- The percentage of patients registered with another practice whose practice received electronic notification of the visit within 24 hours. From July 2016 to December 2016 the centre achieved 100%. The expected target was 95%.
- The unplanned patient re-attendance rate. From July 2016 to December 2016, the centre figures were 4 % which was below the target of 5%.
- Patients who leave the centre without being seen by a clinician. From July 2016 to December 2016 the centre achieved this for all the months apart from December when it increased to 5.7%. The expected target was 5%.
- From 31 October 2016 to 31 December 2016 between 1000 to 1300 patients accessed the service per week.
- Although not part of the commissioner requirements, the centre provided information to show 2528 children (under 16) had been seen by the clinical team from 1 October to 31 December 2016. The average waiting time for this patient group was 22.5 minutes.

The performance reports shared quarterly with Sheffield CCG and Sheffield Teaching Hospital on performance against standards included audits.

- The lead GP for urgent care conducted an audit every three months to review the quality of the clinical notes of all clinicians. This encouraged staff to be conscious of their documentation of consultations and ensure they were working within locally established or national guidelines. The audit enabled managers to monitor trends, productivity, quality, and clinical standards. The audit also provided an opportunity for individual clinicians to review their personal development and contributed towards the revalidation process. The audit for quarter two from 1 July 2016 to 30 September 2016, looked at a total of 40 sets of clinical notes generated by eight clinicians and found that only 30% were satisfactory and in line with agreed guidelines. The actions taken in response were that the provider had delivered individual feedback to clinicians and continued to monitor the quality of clinical notes. The audit of the notes from the 1 October to 31 December 2016 demonstrated a significant improvement. The lead GP for urgent care audited the same clinicians' notes and most were satisfactory and in line with agreed guidelines.
- The lead GP for urgent care carried out a prescribing audit every three months to see whether agreed prescribing guidelines were adhered to. The audit reviewed 112 criteria within 16 sets of records and found that 93.8% were in line with agreed protocols and guidelines. The senior clinicians made several recommendations to prescribing staff to improve adherence to guidelines.
- An audit was carried out to monitor the use of three specific antibiotics groups over a three-month period. A total of 71 records were checked. The audit found that adherence to agreed protocols ranged in from 74%, to 79% across the two medicines. However, one medicine group (Co-amoxiclav) was only 39%. The auditor recommended that staff be reminded of the local CCG protocols at the daily huddle meeting and in one to ones. We discussed the low score with the lead GP for urgent care who explained it was lower for October to December and they had identified this was due to the locum clinicians prescribing. The lead GP told us that they had already communicated this to the locum clinicians and were looking at developing further protocols for them, to improve the prescribing of Co-amoxiclav.
- The lead GP for urgent care carried out an audit to see whether clinicians identified and treated sepsis. The audit focussed on patients presenting to the centre and required clinicians to screen for sepsis in all patients where appropriate to identify the patients that required rapid transfer to secondary care for emergency sepsis management. An audit of 40 cases showed that clinicians achieved 91% adherence to guidelines for sepsis screening in relevant patients.

### 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 safeguarding, infection

Good

# Are services effective?

## (for example, treatment is effective)

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.

- Staff told us they worked within their competencies and would not see patients for whom they did not have the specific skills. For example, registered adult nurses without training to care for pregnancy and children under one.
- The service could demonstrate how they had role-specific training and updating for relevant staff. For example, the practice nurse prescribers were supported to complete an advanced nurse practitioner course and a degree level module in minor illness. The provider held a register of current skills however this did not capture childcare and illness courses completed. For child health, the nurse practitioners had attended in house training for 'recognising the sick child'.
- The provider had identified staff learning needs through a system of appraisals, meetings, and reviews. However, one member of clinical staff reported that they had not had any clinical or management supervision for over a year. Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Staff involved in handling medicines had received training appropriate to their role.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- This included access to required records, which detailed information provided by the person's GP. This helped staff in understanding a person's need.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked collaboratively with the other providers in their area. For example, NHS 111, the local accident and emergency departments and the mental health crisis team.
- Patients who could be more appropriately seen by their registered GP or an emergency department were referred on. If patients needed specialist care, the centre, could refer to specialties within the hospital.
- The service worked with other service providers to meet patients' needs and manage patients with complex needs. The patient's notes were sent to their own GP electronically by 8am the next morning.

### 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.
- 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 caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations, and treatments.
- We noted that staff closed consultation and treatment room doors during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff displayed waiting times at the reception desk so that patients could make an informed decision about whether or not to visit the service.

We received 18 patient Care Quality Commission comment cards all were positive about the service experienced. Patients said they felt the service offered a good or excellent service and staff were helpful, caring and treated them with dignity and respect. The comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the provider's own survey carried out in December 2016 showed out of the 76 patients surveyed, 63 were extremely likely or likely to use the service again and only one would not use the service again. We spoke with six patients during our inspection who all told us that staff treated them with care and respect.

The service had sought feedback from patients by a quarterly patient survey,concerns, complaints, and compliments. In addition, the centre had a patient question of the month. Where patients for one month were asked to drop a green coin in a box to indicate whether they agreed or disagreed with a specific question. For example, staff asked patients 'would you want WIFI in the building', 20 patients responded and 13 said yes.In the waiting room, the centre had 'you said and we did board'. The three points the patients raised were long waiting times, more toys for the waiting room and improved customer services. For each point the staff had provided an explanation of what actions the centre had taken and whether this had led to improvements. An example of this was a patient stating they were unsure of their patient journey in the centre and what to expect. As a result, of this the centre had produced a leaflet describing 'what to expect' that patients were handed on arrival.

### Care planning and involvement in decisions about care and treatment

Some patient feedback from the comment cards stated they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.The staff had recently introduced a survey which covered feedback about the patients journey to the service, receptionists, clinicians and whether the patient would recommend the service. The results of this survey were not available at the time of inspection.The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Some information leaflets were available in different languages.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.

- The centre collected and reviewed the demographics of the service. Staff had access to telephone translation services for those patients whose first language was not English.
- The provider supported other services at times of increased pressure. For example staff from the accident and emergency department referred patients to the walk in centre.
- The centre had specific information about which patients needs they could meet. This helped patients to identify if this was the most appropriate service for them. For example, the centre did not see patients with long-term conditions or those who needed an x-ray.
- Staff had developed a leaflet, to inform patients about their journey through the centre and what to expect.
- During periods of increased demand staff followed an escalation procedure and liaised with other agencies such as the local ambulance services and hospitals. The service also received briefings from other agencies in times of exceptional demand.

### Access to the service

- The centre was open every day between 8am to 10pm, 365 days a year.
- The provider had collated information, which demonstrated that patients often had to wait over 60 minutes. In response, the provider had reviewed the triage system and was in the process of recruiting additional staff. In addition, as per the escalation procedure, staff raised an incident form if a patient had to wait for over four hours.
- The opening times for the centre were widely advertised locally in other GP practices and on the internet.

### Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

- The complaints policy and procedures were in mainly in line with the NHS England guidance and their contractual obligations. However, the policy incorrectly referred patients who were unsatisfied with the centre's response to the CQC, as well as the parliamentary health service ombudsman (PHSO). (CQC do not investigate individual complaints but review the information to inform us about whether the centre was meeting the necessary regulatory requirements).
- The centre had received 40 concerns and 54 compliments in 2016/2017 and had carried out an overall review and found three main themes, clinical, waiting times, and staff conduct. For each theme, the staff had taken action. This included reviewing protocols and speaking with staff.
- Due to the changes in the management team, the business manager had recently been designated the responsible person who co-ordinated the handling of all complaints in the centre. The lead GP for Urgent Care responded to all clinical complaints.
- We saw that information was available to help patients understand the complaints system in the waiting room.
- We looked at three complaints received in the last 12 months and responded to by the lead GP for urgent care. We found they were satisfactorily handled, and dealt with in a timely way, with openness and transparency. Lessons were learnt from individual concerns and complaints and from the analysis of trends.

# Are services well-led?

Requires improvement

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

## Our findings

### Vision and strategy

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

- The service had a mission statement and staff knew and understood the organisational values. The values were to put patients' first, act with commitment, innovation and professionalism and build positive relationships.
- The provider's leadership team visited the centre regularly.

### Governance arrangements

The centre had an overarching governance framework that partially ensured the delivery of good quality care.

- Managers told us all staff, including locums, had access to policies and procedures on the providers group intranet. We found they were not always consistently followed. For example, staff had not always followed the safeguarding tool kit by referring to the local child services team when referring to other agencies such as the police. A significant event form was not always completed when reporting adult safeguarding concerns as per the adult safeguarding policy.There were some arrangements for identifying, recording, and managing risks. The provider completed a fire risk assessment of the premises on 16 January 2017 which documented lack of overall fire safety management within the walk in centre, with no trained/appointed fire marshals or any history of a recent fire evacuation drill being carried. Action was taken by the provider following the risk assessment to address the issues. However these issues should have been dealt with more proactively and been under regular review. There was a staffing structure and staff were aware of their own roles and responsibilities. However, staffs' understanding of who saw young children and babies varied. Some said the GP saw children under one, managers told us it was children under two and the draft paediatric consultation policy stated the GP would see children under three. Although staff told us they only saw patients within their own competency, at the time of the inspection the provider did not keep a record of paediatric trained advanced nurse practitioners. There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- The provider demonstrated an understanding of their performance against the requirements of the CCG. Staff discussed these at senior management and board level meetings. Performance was shared with staff, the local clinical commissioning group and Sheffield Hospitals Teaching Trust as part of contract monitoring arrangements.
- The provider used a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- There were arrangements for identifying, recording, and managing risks.

### Leadership and culture

- On the day of inspection the provider told us they prioritised safe, high quality and compassionate care. Staff told us that managers were approachable and always took the time to listen to them. The managers explained the service had had three changes of manager in the last twelve months and in response to this the head of patient services had acted as the on site manager to help development and consistency.
- The provider had embedded the duty of candour principle in their complaints and significant events systems. This included support training for all staff on communicating with patients about notifiable safety incidents. The managers encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment they gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints. However, the provider did not have a duty of candor policy in place. (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). We found the service kept written records of verbal interactions as well as written correspondence.

There was a 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 daily 'huddles' where staff attended a brief meeting in the huddle room to discuss issues/concerns for the day as

# Are services well-led?

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well as hear about any changes to practice or protocols. There were also monthly team meetings and lead clinicians attended clinical governance meetings that were external to the service.

- There were a number of regular weekly meetings held by the senior managers of One Medicare Limited in conjunction with the centre managers to manage and monitor performance and staffing capacity. For example, the local leadership team and front of house operational meeting and weekly performance meetings. Executive team meetings, which the lead nurse and local business manager attended and senior leadership team meetings.
- 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. However, they told us they had found it stressful at times due to the workload.
- The service retained a permanent local clinical lead, nurse lead and business/finance manager who provided day-to-day leadership and management for the team.
- The service provided was a nurse led, GP supported walk in, see and treat service for the population of Sheffield. The provider tried to ensure a GP was available at the centre most of the time and shortfalls were covered by GP locums. Staff had lead areas of clinical responsibility, For example, infection prevention and control.

### 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 surveys and complaints received. For example, the centre had a patient question of the month. Where a sample of patients throughout the month was asked ask to drop a green coin in a box to show whether they agree or disagree with the question.
- The provider gave us a copy of staff feedback from 1 October 2016 to 31 December 2016, 35% of staff had responded, the areas staff felt were their strengths were staff skill mix, cohesion, and team work. Areas for improvement were staff morale, communication, patient experience and developing specific skills.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and managers.

### Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- Staff from the centre had spent two days at the local accident and emergency (A&E) department, when It was busy, sign posting patients to the walk in centre if appropriate. The managers hoped to work in conjunction with the local A&E to develop this further.
- The centre was developing the role of patient advisers and health care assistants who would be able to signpost or support patients to access the appropriate health and social care.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>**The provider had not fully implemented and monitored systems and processes to ensure compliance with the regulations.This was because:**<br>• A fire risk assessment was completed two days prior to our inspection and action was taken by the provider following the risk assessment to address the issues. However these issues should have been dealt with more proactively and been under regular review.<br>• We found staff did not always consistently follow the policies and procedures. For example, by referring safeguarding concerns to the local child services team when referring to other agencies such as the police. A significant event form was not always completed when reporting adult safeguarding concerns as per the adult safeguarding policy.<br>**This was in breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |