Washwood Heath 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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Key findings

Contents

Letter from the Chief Inspector of General Practice

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We first inspected Washwood Heath Centre on 14 November 2016 as part of our comprehensive inspection programme. The overall rating for the service was requires improvement. The full report from the November 2016 inspection can be found by selecting the 'all reports' link for Washwood Heath Centre on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection, carried out on 1 March 2018 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations we identified in our previous inspection on 14 November 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

At this inspection we found:

- The provider had made significant improvements to address the breaches and improve the service delivered since our previous inspection in November 2016. This had focused on improving engagement and support for staff.
- The service had clear systems to keep people safe. This including arrangements to safeguard children and vulnerable adults from abuse, recruitment processes, infection control and medicines.
- The provider regularly reviewed staffing and was taking action to adjust this in order to meet changes in service demand.
- The service had reviewed processes for managing patients who might be in need of urgent attention. Reception staff were aware of these processes and had received training to support the identification and escalation of any concerns.
- Risks were generally well managed although we identified processes for monitoring emergency medicines and equipment that were not consistently followed.
- The service had processes for reporting, investigating, acting on and learning from safety incidents to minimise the risks of reoccurrence and improve processes. Learning was shared with all staff including locum staff.
- The service had systems for supporting staff to keep up to date with best practice guidance.

Summary of findings

- Staff received opportunities for learning and development and received regular supervision.
- There was limited evidence of clinical improvement activity such as clinical audit.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- The service had a high proportion of patients whose first language was not English. Interpretation and translation services were available however, the availability of patient information in alternative languages and formats was limited.
- The provider worked with commissioners to provide services to meet the needs of the local population and reduced demand on other services such as accident and emergency departments.
- The provider was meeting contractual obligations for seeing patients within four hours.
- Information about how to complain was available and easy to understand. Information from complaints was used to support improvements in the quality of care.
- There were clear leadership and governance arrangements in place. Staff were aware of the vision and values of the organisation.
- The service proactively sought feedback from staff and patients which it acted on.
- There was a focus on continuous learning and improvement within the organisation.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Review processes for checking emergency equipment.
- Review access to information in languages and formats relevant to the local population.
- Consider reviewing complaints to identify any themes or trends.

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**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Washwood Heath Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector and a GP specialist adviser.

Background to Washwood Heath Centre

Washwood Heath Centre is run by Virgin Care Vertis LLP and provides NHS walk-in facilities for members of the public who require treatment of minor illnesses and injuries. The service is nurse led. It was originally commissioned in 2011 and current commissioning arrangements are held with Birmingham Cross City CCG.

Washwood Heath Centre is located in the Washwood Heath Health and Wellbeing Centre. The building is shared with a GP practice, community health teams and a pharmacy and is managed by NHS Properties. It is situated in a residential area with links to public transport. There are car park facilities for patients using the Health and Wellbeing Centre.

Patients do not need to be registered or need to make an appointment to use the service. The service is open 9am to 9pm daily, including weekends and bank holidays (with the exception of Christmas Day). Patients access the service in person and wait to be seen.

Approximately 30,000 consultations took place at the walk-in centre during the last year. The service is located in an area with higher than average levels of deprivation and is ethnically diverse. The population age is younger than both the CCG and national average.

The service has close links with the provider's other walk-in centre Warren Farm Urgent Care Centre located in Kingstanding, Birmingham. The two services shared the same contract and some staff including the service manager and clinical manager.

The service is currently staffed with a minimum of two Advanced Nurse Practitioners (ANPs), all independent nurse prescribers. Where possible the provider aimed to have three staff on duty in the afternoon to help manage workloads at the end of the day and at weekends. At the time of inspection the service employed four ANPs (including the clinical manager) who were supported by locum staff. There was also an assistant service manager and a team of reception / administrative staff.

Good

Are services safe?

Our findings

At our previous inspection on 14 November 2016, we rated the service as requires improvement for providing safe services. We found the arrangements in respect of sharing key learning and patient safety information among all staff (such as significant events and safety alerts) were not adequate.

These arrangements had significantly improved when we undertook a follow up inspection on 1 March 2018. The service is now rated as good for providing safe services.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and on-going training.
- The provider had systems to safeguard children and vulnerable adults from abuse. There were safeguarding policies in place which were accessible to all staff and a named safeguarding lead for the service. Staff received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns and were able to provide examples of this.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Appropriate checks were also undertaken for staff employed on a locum basis. There were systems in place for checking staff registration with their professional bodies on an on-going basis.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The premises were visibly clean and tidy and there was a dedicated infection control lead for the service. Regular infection control audits were carried out including hand washing audits. We reviewed the latest infection prevention and control environmental audit dated December 2017. This did not raise any major concerns.
- NHS Properties managed the building in which the service was located. The premises appeared well maintained. We saw risk assessments in place in relation to the health and safety of the premises including legionella, fire and the control of substances hazardous to health (COSHH). There were records showing that fire equipment was regularly serviced, alarm testing carried out and of fire drills having taken place. There were systems for safely managing healthcare waste.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. We saw that equipment had undergone portable appliance testing (PAT) for electrical safety and calibration checks to ensure the equipment was in good working order within the last 12 months.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff told us that there was no contractual requirement for the number of staff required however, they reviewed capacity and demand on a daily basis to help inform any changes to staffing levels. Staff told us from April 2018 clinical staffing was to increase to three ANPs on at all times.
- At our previous inspection the provider had been heavily reliant on locum staff to run the service. Although there was still a reliance on locum staff the provider advised that they had recently recruited three ANPs (one was in post and the other two were shortly due to start). They also spoke about exploring different skill mixes due to difficulties in recruiting ANPs.

Good

Are services safe?

- There was a system for checking agency staff commitments each week to ensure it matched the staff rota. If short notice cover was required additional shifts would be offered to permanent staff or the clinical lead would fill in.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. There was a clear process in place for ensuring clinical staff were alerted to any patients who might require more urgent attention. Reception staff had received specific training to support them with this process. Clinical staff demonstrated an understanding as to action they would take in the event of serious infections such as sepsis. Staff received basic life support training and sepsis training had recently been incorporated into the provider's mandatory training programme.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- Staff had access to emergency equipment and medicines which were routinely checked to ensure they were ready for use when needed. However, we noticed that an item was recently out of date and that there were some gaps in the checking process.

Information to deliver safe care and treatment

- The IT systems used by the service were not compatible with other systems. Staff were not able to access patient summary care records or medication history. This information was collected as part of the patient consultation.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The provider was required as part of their key performance indicators with commissioners to share information relating to their consultations with the patients GP within 48 hours.
- Written information was provided by clinicians when transferring patients to other services such as transfers to hospital.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use. Processes were in place for checking medicines and staff kept records of medicines administered as stat (or one off) doses.
- There were certain medicines that clinical staff would not prescribe and these were displayed in reception and the clinical rooms so staff and patients were aware. Clinical staff told us that where they identified patients coming in for regular medication such as for the management of long term conditions they notified the patients usual GP.
- There was evidence of actions taken to support good antimicrobial stewardship. Staff had access to local antimicrobial prescribing guidance and discussions took place at the clinical governance meetings. The service was supported by a regional pharmacy lead and staff were trying to establish a link with the CCG pharmacy team.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. These were usually recorded electronically but paper forms were also available if needed. Staff (including the locum staff we spoke with) understood their duty to raise concerns and report incidents and near misses and were encouraged to do so.

Good

Are services safe?

- There was a total of seven incidents reported in the last year. We saw that these had been reviewed and investigated. Staff were able to share examples of incidents and action taken. The service learned and shared lessons where identified both locally and across the organisation For example, staff told us that the new red flag process had originated from an incident. Incidents and learning were discussed at local clinical governance meetings and more serious incidents were shared at a regional level. They were also routinely shared with the CCG as part of the contract monitoring reports.
- The service learned from external safety events and patient safety alerts. The service had mechanisms in place to disseminate alerts to all members of the team including locum staff. There was a centralised process for receiving safety alerts such as those received from the Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS). These were reviewed and disseminated for action within individual service teams as appropriate. The clinical lead acted on them locally and was able to provide an example of an alert they had responded to. Alerts were stored in staff information files and staff were reminded to look at this.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 14 November 2016, we rated the service as requires improvement for providing effective services. We found the arrangements in respect of the induction processes for locum staff and supervision of all clinical staff were not adequate. We also identified an area the provider should improve which related to managing risks relating to the limited visibility of patients in the waiting area.

We found improvements had been made in the areas identified when undertook a follow up inspection on 1 March 2018. However, the service remains rated as requires improvement for providing effective services as systems for supporting quality improvement such as through clinical audit were not adequate.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. Staff told us about NICE guidance relevant to the service that had been shared with them, including guidelines relating to the management of sore throats, sepsis and urinary tract infections.
- Current copies of the British National Formulary (BNF) were available for staff to use, staff could also access the BNF on line.
- Resuscitation council guidance was displayed in clinical rooms.
- Since our previous inspection in the provider had reviewed the process for identifying and managing patients that presented with 'red flag' or urgent symptoms. A formal training module and assessment process was available to all staff including reception staff. The provider continually reviewing the process to ensure it was working as intended so that those with the most urgent need were prioritised for triage and treatment.
- Staff assessed and managed patients' pain where appropriate.
- At our previous inspection we identified that the waiting area was not visible to reception staff and the risks to patients relating to this had not been considered. At this inspection we saw that a risk assessment had been completed. Management of urgent patients had been strengthened and clinical staff were aware to continuously review the list of patients waiting and scan the waiting room when they called in patients to check for patients whose needs may have changed.

Monitoring care and treatment

- The provider attended quarterly contract review meetings with their commissioning CCG. Contract monitoring reports included information about staffing, activity, incidents and complaints and patient feedback.
- The service was meeting its locally agreed target set by its commissioner of seeing patients within 4 hours. This was monitored on a monthly basis and during 2017 the provider was achieving 100%. The provider also had its own internal target of seeing patients within 2 hours. During 2017 the monthly average achievement of this internal target ranged between 78% and 99%.
- We noticed from reports presented to the February 2018 clinical governance meeting that waiting times at Washwood Health Centre were longer than at the providers other local walk in centre. However, there was no evidence that the differences were discussed to identify the potential reasons for the differences and actions to address. For example:
  - The provider reported that 48.3% of patients waited less than an hour compared to the providers other service of 78.5% and 27.4% of patients waited between one and two hours compared with the providers other service of 17.2%.
  - The provider also monitored the number of patients attending the service who did not wait to be seen. At Washwood Heath Centre there were 107 patients who registered with the service but left before being seen and 310 patients who chose to leave without registering. This was a higher proportion than the providers other service which showed 45 patients registered with the service but left before being seen and 104 patients chose to leave without registering.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Monthly activity reported at the February 2018 Clinical Governance meeting showed the total number of patients seen for each service was 2787 patients at Washwood Health Centre and 3065 at the providers other service.
- The provider also measured productivity of staff to help identify staffing needs. Staff saw on average 3.2 patients per hour. This information was used to help determine staffing needs.
- We reviewed some evidence of clinical improvement activity although this was limited. The clinical lead undertook quarterly audits of consultations including those undertaken by locum staff. Results were fed back to individual clinicians. The service reported that prescribing audits were undertaken routinely however, there was no information available at a local level as to how the service performed.
- The clinical lead told us that they had undertaken an audit in response to a complaint where they had reviewed the management of patients presenting with a urinary tract infection (UTI) which had led to changes in processes. Although there was evidence of a discussion at a clinical governance meeting the audit had not been documented. Following the inspection the provider documented retrospectively details of the audit and action taken. A re-review of approximately 100 patients presenting with symptoms of a UTI was undertaken which showed all patients reviewed received appropriate prescribing advice and 60% were given safety netting advice. A re-audit was suggested for June 2018. The provider also forwarded a copy of their audit plan for 2017/18 for driving clinical improvements.

Effective staffing

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

- Staff were appropriately qualified for the roles they undertook.
- The provider had an induction programme for all newly appointed staff in which they were given opportunities to shadow the clinical lead.
- There was a resource file available for staff who worked on a temporary basis. This contained various guidance and information that might be needed during a shift.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Mandatory training requirements of staff were clearly defined and uptake of this training monitored.
- Staff were encouraged and given opportunities to develop.
- Staff received ongoing support. This included one-to-one meetings and appraisals to highlight where staff may require further training. Staff who were new to the service underwent a probationary period and appraisal at three months with regular one to one meetings.
- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing, through the regular consultation audits.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. Staff were able to talk us through the process.

Coordinating care and treatment

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

- Information relating to patient consultations was routinely shared with the patients usual GP to support the continuity of care. Staff told us that they would also write to the patient's GP if they had any specific concerns regarding patients attending.
- Where patients were not registered with a GP staff told us that they tried to encourage patients to register and would advise them of GP practices nearby.
- Referral letters were sent with patients when transferring them to other services such as accident and emergency. The provider monitored referrals made to other services and had reviewed a sample to ensure these were appropriate.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Staff were aware of and took action in line with requirements for the reporting concerns to relevant agencies.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff had access to contact details for services that might be needed for example, district nurses, sexual health and dental emergencies.

Helping patients to live healthier lives

Patients attending the service were generally seen for minor ailments and not part of any on-going long term care or treatment. Where risks were identified the patients usual GP was informed.

- Where appropriate, staff gave patients advice on their presenting condition as part of the consultation so they could self-care and written information if needed.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making for patients who may lack mental capacity and for children and young people.
- Mental Capacity Act training was part of the provider's mandatory training.

Good

Are services caring?

Our findings

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff demonstrated an understanding and non-judgmental attitude to patients. Evidence gathered as part of the inspection indicated that staff understood patients' personal, cultural, social and religious needs and supported those. Equality and Diversity training and Prevent training was provided to all staff. Uptake of training was monitored, 90% of staff had completed their Equality and Diversity training.
- Staff told us that consultations were not time limited so if a person needed longer for example, a patient with a learning disability they could provide this.
- All of the 15 patient Care Quality Commission comment cards we received were positive about the service experienced. This was is in line with the results of the NHS Friends and Family Test and other feedback received by the service.
- Results from the NHS Friends and Family test (between April and December 2017) showed in quarter one 69%, quarter two 85% and quarter three 81% of patients said they would recommend the service to others.
- The provider had carried out its own in-house patient satisfaction survey in December 2017. Based on 218 forms 94% of patients provided a positive response about the service they had received.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care although information in alternative languages and formats to English was limited.

- The provider had a high proportion of residents in the area (over 40%) who did not speak English as a first language. Interpretation services were available for these patients if needed. Information as to how to contact interpretation services was available to staff in the clinical rooms. We saw some notices displayed in languages other than English such as chaperone notices.
- We spoke with staff about information available for patients to take away to help understand care and treatment and whether this was available in languages and formats other than English. Senior staff told us that there were websites in which information in multiple languages could be obtained for patients, however not all staff were aware of this.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about their care and treatment.
- Results from the provider's own patient survey (December 2017) showed 59 out of 71 patients 83% said they felt involved in decision about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Privacy curtains and a mobile screen were available to protect patients' privacy and dignity if needed.
- Conversation could not be overheard in the consulting rooms.
- There was an area in which staff could take patients if they wished to speak in private at reception. A notice was displayed advising patients of this.
- Staff understood their duty to maintain patient confidentiality and signed confidentiality agreements as part of their contract. They were also required, as part of the provider's mandatory training, to undertake information governance training.
- Results from the provider's own patient survey (December 2017) found:
  - 90% of patients who responded said they felt respected in regards to privacy offered during their appointment.
  - 90% of patients who responded said they felt they were treated with dignity and respect.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 14 November 2016, we rated the service as requires improvement for providing responsive services. We found the arrangements for obtaining feedback on the patient experience was not adequate. We also found an area the provider should improve, the availability of complaints information in a language other than English was not available.

These arrangements had significantly improved when we undertook a follow up inspection on 1 March 2018. The service is now rated as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. Staff told us that consultations were not time limited which enabled them to be more flexible and give more time to patients who needed it for example those with mental health issues or autism. Staff were able to give examples of this.
- The provider engaged with commissioners to secure improvements to services. The provider told us how they planned to improve local access to primary care, help reduce health inequalities, the burden on accident and emergency departments locally and support local out of hours primary care. The provider told us that they opened an hour later at this location as they had identified a need for this.
- The provider carried out access surveys on an ongoing basis and collected daily activity reports which enabled them to continually review capacity and demand for the service. Data from the access survey (October 2017) of over 400 patients showed most self referred (51%), this was followed by referrals from NHS 111 (22%) and the patients GP (16%). Of patients who responded 44% said they had tried to book an appointment with their GP before attending and 3% were not registered with a GP at all. Had the walk-in centre not been opened 56% of patients said they would have gone to accident and emergency instead and 24% to their GP.
- In response to demand the provider told us that they tried to have an additional clinical member of staff on in the afternoon to manage the end of the day and to reduce number of patients not seen who may otherwise attend services such as accident and emergency or out of hours GP services. There were also plans to increase the usual number of clinical staff on duty at all times from two to three after April 2018 and recruitment had taken place to secure additional staff.
- The facilities and premises were appropriate for the services delivered. They were accessible to patients with mobility difficulties. At the time of the inspection we saw that there was adequate seating available for patients waiting. Patient parking was also available.
- There were baby changing facilities available which were shared with other services located in the building.
- A hearing loop was also available for those who needed it.
- The service provided support to patients who were not registered with a GP. Information was printed and given to patients regarding local GP practices.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- As a walk-in service patients were able to access care and treatment at a time to suit them on a sit and wait basis. The service operated seven days a week from 9am to 9pm, with the exception of Christmas Day when it was closed.
- Some patients were referred from other services such as NHS 111, the patient's own GP or the ambulance service.
- The provider was meeting their locally agreed targets as set by their commissioner for seeing patients with four hours:
  - 100% of patients seen at Washwood Heath Centre during 2017 were seen within the four hour target.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients with the most urgent needs had their care and treatment prioritised. Patients were routinely seen in order of attendance however those with urgent symptoms were highlighted to clinicians for triage within 15 minutes.
- Staff told us that they would let patients know if there was likely to be a long wait to be seen.
- Feedback on waiting times from the CQC comment cards was mixed some patients said their wait was too long while others said they were seen quickly.
- The provider had a system in place at the end of the day for non-urgent patients. Patients were not turned away but advised that they may not be seen so that they had the option to come back in the morning.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and displayed in the waiting area. There was also a leaflet for patients to take away which provided a number they could call if they required the information in an alternative format or in a different language.
- The complaints policy and procedures were in line with recognised guidance. We saw that seven complaints were received in the last year. We reviewed a recent complaint and saw that it was handled appropriately and in a timely way. Patients were made aware as to how they could escalate their concerns if they were unhappy with the response received.
- The service learned lessons from individual concerns and complaints, these were discussed and shared with staff at clinical governance meetings. Staff told us about guidance that had been reviewed in response to a complaint.
- The provider recorded both verbal and written complaints to support learning.
- Complaints were also shared with commissioners as part of contract monitoring.
- Although the provider reviewed individual complaints these were not analysed to identify themes or trends.

Are services well-led?

Good

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

Our findings

At our previous inspection on 14 November 2016, we rated the service as requires improvement for providing services that were well-led. We found the arrangements in respect of communicating and engaging with locum staff such as sharing learning were not effective and systems for monitoring the quality or the patient experience were limited.

These arrangements had significantly improved when we undertook a follow up inspection on 1 March 2018. The service is now rated as good for providing responsive services.

Leadership capacity and capability

Leaders demonstrated they had the skills to deliver high-quality, sustainable care.

- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges facing the service and were taking action to address them. These were shared with us such as difficulties in recruiting Advanced Nurse Practitioners and looking at new staffing models.
- Senior managers were accessible throughout the operational period, with an effective on-call system that staff were able to use.
- Leaders at local and regional levels were visible and approachable. They worked closely with staff in the delivery of the service.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. There were forums in place to support the local management to develop in their roles.

Vision and strategy

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

- Staff were aware of and understood the vision, values and strategy of the organisation and their role in achieving them. New staff received a corporate induction where these were discussed and appraisals were focussed around these visions and values.
- Staff we spoke with told us about a shared vision of providing care good enough for their own families. There were clear values and behaviours expected of staff which included striving for better, providing a heartfelt service and team spirit.
- Information was regularly shared with all staff (including regular locums) through staff meetings and news bulletins. This helped keep staff informed with what was going on across the organisation.
- The provider worked with commissioners to plan the service and meet the needs of the local population.
- A leaflet was available for patients which set out what they could expect from the service and of their own responsibilities.

Culture

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

- Staff we spoke with said they felt respected, supported and valued.
- The service focused on the needs of patients.
- Leaders and managers took action to address behaviour and performance that was inconsistent with the vision and values of the service.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. Although, there were no specific examples, there was a policy in place and the incident report asked staff to log if duty of candour applied.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for supporting staff with the development they need. Staff received regular annual appraisals and were supported to meet the requirements of professional revalidation where necessary. Clinical staff were given protected time for professional development and received evaluation of their clinical work.

Are services well-led?

Good

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

- Clinical staff were encouraged to share specific skills and knowledge at the clinical governance meetings. Staff told us that these sessions had been running for approximately six months and had included topics such as the management of paediatric patients.
- The provider operated a system where potential staff had the opportunity to come and look at the service before taking the position.
- There was a strong emphasis on the safety and well-being of all staff. The provider operated support through the employee assistance programme. Staff had access to a wellness portal where they could obtain support and advice (including where this was non- work related). Staff were encouraged to take breaks though the 'love your lunch' promotion. The provider also ran events to celebrate staff who had gone the extra mile or provided a positive contribution to the service.
- Arrangements were in place to support staff safety while on duty.
- The service promoted equality and diversity which they included as part of the provider's mandatory training.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were in place. The provider held monthly local clinical governance meetings jointly with their other walk-in centre. They also held regional clinical governance meetings.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. Staff would meet informally on a daily basis for the 'clinical huddle' in which they would decide who would take on the role of shift lead and co-ordinate breaks to help ensure the smooth running of the session.
- Leaders had established proper policies, procedures and activities to ensure safety and these were available to staff.
- Regular newsletters were shared across the organisation which enabled information and learning to be shared for example, in relation to safeguarding issues and safety alerts.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The clinical governance meeting was the main forum for discussing risks issues and performance, standing agenda items included key performance indicators, incidents and complaints, patient feedback as well as other opportunities for shared learning and discussing service improvement. Meetings were planned for the year so staff knew when they were. There was a corporate risk register for monitoring more serious risks.
- The provider had processes to manage current and future performance of the service. Data collected routinely by the service allowed them to monitor capacity and demand and to ensure the service was meeting contractual requirements.
- Performance of clinical staff was monitored through consultation audits and referral decisions.
- Performance was shared with staff at the clinical governance meetings and the local Clinical Commissioning Group (CCG) as part of contract monitoring arrangements. Service activity and details of any incidents and complaints was routinely shared with the CCG. However, we were advised the CCG did not routinely ask for details of the key performance indicators relating to waiting times.
- There was limited evidence of service improvement activity such as clinical audit.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Performance information was combined with the views of patients and were standing agenda items at the clinical governance meetings.

Are services well-led?

Good

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

- Information was collected on a daily basis by reception staff. Daily reports highlighted any issues occurring during the shift and patient activity.
- The service submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services. The provider participated in the friends and family test where patients were invited to say whether they would recommend the service to others. They also carried out an in-house patient survey and reviewed comments on the NHS choices website. The provider shared with patients changes they made in response to feedback, through the 'You said, we did' programme. Action taken in response to feedback on waiting times included a review of staffing need and plans to increase staffing from April 2018 and for the provision of water.
- Staff were able to describe to us the systems in place to give feedback and were able to provide examples where feedback had been acted on. This included changes to the way medicines were recorded to ensure a good audit trail.
- The provider carried out annual staff surveys. Due to the small number of staff at the walk in centre information was reported at a higher level so that individuals could not easily be identified from responses. Managers told us as a result of themes from the previous staff survey the senior management were carrying out listening weeks with staff.
- All staff were invited to regular team meetings. Those who could not attend, including regular locums, were sent copies of the minutes from meetings.
- The provider was working to establish links with other services to improve skills and knowledge. For example the clinical lead was working with a safeguarding lead at the CCG and had started to attend CCG led safeguarding meetings , they were also trying to establish links with the child assessment unit for the personal development of staff.

Continuous improvement and innovation

There were systems and processes for learning and improvement.

- Staff were encouraged to identify and report on areas of service improvement at clinical governance meetings.
- Following our previous inspection the provider was aware of the need to improve staff communication and had worked to improve this.
- Staff spoke about the difficulties as an independent provider working in the NHS in building networks. They were working with the CCG to try and establish greater involvement in areas such as safeguarding and medicines to help build on skills and knowledge.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provider was not proactive in undertaking clinical improvement activity such as clinical audit. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.