

# Liverpool Community Health NHS Trust

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## Walk in centres

### Quality Report

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

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

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

# Summary of findings

## Ratings

Overall rating for Good		Good	
Are Walk in centres safe?		Good	
Are Walk in centres effective?		Good	
Are Walk in centres caring?		Good	
Are Walk in centres responsive?		Good	
Are Walk in centres well-led?		Requires Improvement	

# Summary of findings

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# Summary of findings

## Overall summary

The Walk-in centres were managed through the ambulatory care directorate. The centres had both clinical and service manager leadership.

There were effective systems and processes to provide safe care and support for patients. Patient safety was monitored and incidents were investigated to help learning and improvement. There was not always enough staff to make sure that patients referred to the services could be seen promptly. This may impact on the quality of care delivered by the service.

Systems were in place to support vulnerable patients. Patients and their relatives spoke positively about their care and treatment.

Staff followed national guidelines and had clinical procedures in place based on national and regional guidance. The trust took part in local clinical audits but

did not have a clear audit calendar. Changes to the service information system did not facilitate the services ability to communicate with external partners such as GPs in a timely fashion. The clinical managers told us that previously they had been able to carry out systematic peer reviews to ensure that practitioners were clinically effective and adhering to best practice guidance. The changes to the information system in 2010 meant that this was not possible. We were told that the service was about to start procurement for a new Information system.

Staff told us and records showed that they had been appropriately supported with training and supervision, and encouraged to learn from mistakes. We found that the staff were hard working and caring. The team felt supported locally but did not have regular staff meetings due to pressure on staffing and staff were not aware of the trust visions and strategies.

# Summary of findings

## Background to the service

As part of the inspection process we visited three walk in centres run by the Trust. We spoke with 50 patients and relatives. We observed care and treatment and looked at care records. We also spoke with 26 staff at different grades, including the clinical and service managers. The city centre walk in centre had recently relocated to a newly renovated building and the process of registration of the new location was in progress.

The Trust managed four walk in centres across the geographical area in Liverpool and South Sefton. Each Walk in Centre was nurse led and was open every day of the year with extended opening hours. They offered a range of treatments from experienced specially trained nurses. The centres provided consultations, advice and treatment for minor injuries and illnesses. They also

provided emergency contraception, advice and Chlamydia screening for under 25's. The Liverpool City Walk in centre was based in a new building alongside the sexual health service.

We were able to observe care and treatment at three walk in centres and were able to track patients care through the electronic patient system.

The Walk in centres were managed through the ambulatory care directorate. The centres had both clinical and service manager leadership. We reviewed comments from people who contacted us to tell us about their experiences. We also reviewed performance information about the service.

## Our inspection team

Our inspection team was led by:

**Chair:** Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

**Head of Inspection:** Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Nurse, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

## Why we carried out this inspection

Liverpool Community Health NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health

services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

## How we carried out this inspection

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

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

# Summary of findings

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Liverpool Community Health NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between

13 and 15 May 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 23 locations including three community inpatient facilities ward35 Aintree Hospital, and wards 9 and 11 in the Alexandra Wing, Broadgreen Hospital. The remaining locations included three walk-in centres and various community facilities. We carried out an unannounced visit on 13 May to the evening district nursing services.

## What people who use the provider say

We spoke with over forty patients and their relatives during our inspection of the walk in centres and the majority of people were positive about the services and care they had received at the walk in centres. Some people acknowledged that the service had been busy

and they had to wait for a consultation. Other people told us that they had felt uncomfortable or embarrassed going to the walk in centre in the same building as the sexual health service.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

Remedial action should be taken to ensure people's privacy and confidentiality when attending the colocated services to ensure that people were seen in a timely manner according to different service needs.

The trust should continue to review its staffing levels and ensure that plans are in place to address the shortfall and meet the increased demand on the service.

The trust should continue to review the appropriate transfer of information to primary care through robust Information systems.

### Action the provider **COULD** take to improve

The trust could improve the integrated working externally with partners as currently no planned engagement meetings with stakeholders.

## Liverpool Community Health NHS Trust

# Walk in centres

### Detailed findings from this inspection

The five questions we ask about core services and what we found

Good 

## Are Walk in centres safe?

By safe, we mean that people are protected from abuse

### **Incidents, reporting and learning**

We asked staff directly if they reported incidents. They told us that they reported incidents and were confident to report them. The service had clear systems in place to record incidents, and learning. The manager was able to demonstrate the data system and was able to identify all the incidents including trends for the last twelve months.

The service had clear mechanisms in place to report and record safety incidents, concerns and near misses, and allegations of abuse internally and externally. Staff told us they were trained to use the electronic reporting system Datix and reported that they appreciated the recent changes to provide feedback from the system to acknowledge that they had reported an incident.

The service also completed a dashboard to monitor key clinical quality indicators. We reviewed the data provided as part of our inspection. Staff told us that due to the volume of the caseload they did not feed into the core safety dashboard but did keep a clear log of any safety issues. The service lead was able to describe the processes

for ensuring an accurate picture of safety performance through the use of multiple information sources including patient safety incidents, complaints, health and safety incidents and clinical audits

We saw examples of incidents and subsequent root cause analysis. We saw that action plans had been completed in response to incidents. One example showed that the service had undergone a review of communication to external partners to ensure that information was shared in a timely manner.

We found that the service had been involved in safety audits such as infection prevention and control with no serious concerns identified. There was no evidence of any serious incidents reported in the last twelve months for the service and staff told us about a potential incident which had been reviewed and systems put in place to mitigate a future risk.

### **Cleanliness, infection control and hygiene**

During our inspection we observed that all the centres provided adequate personal protective equipment. Staff

## Are Walk in centres safe?

we spoke with confirmed that they had access to appropriate equipment and were able to talk through the principles of good hand hygiene and infection control measures within the centre.

We saw evidence of clinical cleaning schedules to be carried out at various intervals such as after use, daily and weekly. All the centres had comprehensive information on infection prevention and control procedures.

The service had carried out infection control environmental audits. Compliance was set at 85 % and we saw evidence of 99% and 87% compliance.

### Maintenance of environment and equipment

The three Walk in centres we inspected were in well maintained buildings which were clean and tidy. Two of the centres were in newly built or renovated buildings which were easily accessible. Each clinical room was well stocked with appropriate equipment. We were told that the remodelling works at the fourth walk in centre had been agreed by the local commissioning group and plans were underway to start the renovations in the summer.

Staff we spoke with confirmed that they had access to appropriate equipment and were able to talk through the process for checking equipment. A maintenance service contract was in place with the Biomedical engineering department at a local acute trust

Equipment required in case of a cardiac arrest was stored on suitable trolleys that were able to contain the equipment safely if it was moved. We saw completed checklists to ensure that emergency equipment was checked regularly and was well maintained.

### Medicines

Staff records showed that appropriate training had been carried out in line with professional standards for the management of medicines by nurses. Staff we spoke with were clear on which drugs they used and that they had received the relevant training. Staff told us that they usually had one nurse prescriber per shift. Staff told us that they were able to prescribe medicines through use of patient group directives (PGDs). Patient group directives refer to a group of medicines that can be given by a practitioner who has had training and knowledge which meets PGD guidelines provided by the trust.

Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked. The service had access to a pharmacy technician who carried out weekly stock checks.

Records showed clear documentation of medication with standardised medication charts across the service.

### Safeguarding

Adults and children were protected from abuse and staff were trained to deal with suspicion of abuse. Staff we spoke with were able to describe the signs of abuse and the appropriate actions and systems for reporting allegations of abuse. We saw clear examples of safeguarding policies and procedures flow charts algorithm.

Staff told us that they had access to advice and support from the trust safeguarding team. We saw that alerts were place on the electronic records system which we witnessed in use.

### Records

We found that the standard of record keeping was comprehensive and easily understood. During our inspection we reviewed 15 sets of patient records. In all the records we looked at documentation was accurate, signed and dated, easy to follow and gave a clear plan and record of the patients care and treatment. The records were in electronic format.

The inspection team found that the records contained clear recall advice and safety netting. The clinical consultations were very thorough with appropriate recording of the presenting condition and any relevant medical history.

The staff told that there had been an issue regarding the paper transfer of information to Health visitors and GPs by post. All information regarding an individual patient had to be printed off from the electronic system and then sent out by post. This may have an impact on the timely communication of information about a patient. The manager told us that there was a meeting booked to discuss the use of NHS Net to transfer data but no formal plans were in place to address the issues.

### Lone and remote working

There was a lone workers policy in place for the service. We saw evidence of a protocol for the delivery of emergency care outside the walk in centres. This was in place to ensure that the safety of staff was considered at all times.



## Are Walk in centres safe?

A panic button for staff to call for assistance was available at each computer terminal at each of the walk in centres.

We found that staff did have access to security staff. The city centre building had full time security cover but other centres had part time security in the evenings and at weekend.

### Assessing and responding to patient risk

The records we reviewed were comprehensive and highlighted appropriate clinical risks and alerts.

Staff told us that incidents and complaints were reviewed. We saw that feedback was given via email but not at face to face staff meetings. Staff told us that informal support was available to talk through patients to assist in assessing and managing specific risks. We did not see any evidence of shared learning across the Walk in centres at individual clinical level.

The service had clear processes in place to ensure the recognition of severely ill people and to manage the deterioration of acutely unwell patients.

### Staffing levels and caseload

We reviewed the staffing levels across the service. We noted that staff had reported several incidents when staffing had not been adequate in the service. The staff told us that they knew how to access more staff if required and were aware of the escalation policy for short term management of staff shortages/capacity issues.

We noted that the current sickness rate was 4.8% against an England average of 4.3%. Some staff told us that the sickness levels had been higher than usual as they had

been waiting to for new staff to start, had been carrying vacancies and expected to work extra hours to maintain the staffing levels. Some staff told us they were exhausted and anxious about the workload. This was not the case across the whole service. Some staff told that activity had decreased since moving to new premises.

We found that the issue of staffing and increased volume of patients through the service was on the service risk register. The service had identified the increased use of agency /overtime due to vacancies and difficulties in meeting the increased demand on the service. We also saw several incidents reported on the electronic risk reporting system Datix in relation to the lack of staff at the walk in centres.

The manager told us that they were aware of the issues and had meetings booked to address the staffing levels during the week of our inspection. Staff told us that they felt the local managers were aware and supportive but were not sure senior managers were aware or that the problem was going to be fixed.

### Managing anticipated risks

We reviewed the local service risk registers which were then incorporated into the wider directorate risk registers. The risks identified had control measures in place to manage the risk. We did not see clear evidence of how the risks from the directorate were visible to the executive team.

We saw examples of business continuity planning for each of the Walk in centres. The clinical managers were able to describe the role the service was play as part of a major incident in the city. Such as, recent plans to

# Are Walk in centres effective?

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

## Evidence based care and treatment

The delivery of care was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). For example "Guidelines for requesting and interpretation of x-ray by Nurse Practitioners."

Departmental policies and procedures were easily accessible electronically and staff were able to show us how they accessed policies. Use of NICE Guidance, best practice patient advice leaflets and other information was readily available to the nursing staff through the electronic record system.

We saw staff attending to people's needs appropriately and in a timely manner. We found evidence of examples of clinical pathways followed to ensure that patients were treated effectively, for example, antibiotic prescribing and management of common infections in primary care and safeguarding protocols. Staff told us that they were working hard to ensure consistency across all the Walk in centres to ensure a standardised approach to care.

We were shown examples of audits on the clinical management of patients attending the Walk in centres. This included an audit of triage on arrival at the centre to ensure that patients had been treated effectively and safely in a timely manner. The results showed that overall patients were being triaged effectively in a timely manner.

We found examples of printed information available to ensure that staff had effectively prescribed medicines. We saw an Antibiotic update 2014/15 which linked the latest NICE guidance for respiratory tract infections with appropriate clinical actions to consider before prescribing antibiotics.

## Pain relief

The service had a number of nurse prescribers and aimed to have a minimum of one per shift. We observed that staff were able to follow guidance within their scope of competency to prescribe pain relief medication. Staff told us that they were able to prescribe medicines through use of patient group directives (PGDs).

## Nutrition and hydration

Staff told us that they were unable to provide food at the Walk in centres but we observed that water dispensers were available. The inspector identified that the provision of nutrition was not appropriate in this case.

## Patient outcomes

The service had some processes for monitoring the outcome of care provided to patients. The Walk in centres reported monthly on the National Accident and Emergency department Clinical Quality indicators. This was a national set of targets which included the monitoring of the four hour waiting time for treatment, attendance and the number of patients who choose to leave without being seen. The service had consistently performed well in regard to all the quality indicators.

We were shown examples of audits on clinical management within the walk in centres. This included an audit of x-ray which showed that Nurse Practitioners were not missing any fractures when reviewing x-rays. The results of an audit of triage of patients on arrival to the service showed that patients had been triaged appropriately and managed in a timely manner.

We were shown the local key department performance indicators which included, mandatory training, complaints, sickness, staff turnover, performance reviews, and financial indicators such as agency expenditure.

## Competent staff

The service had clear systems in place for supervision and appraisal. Appraisals were being undertaken and staff said this was part of the culture of the service. One person told us that the trust had introduced a new Performance development review (PDR) policy but there had been no training for implementation and there had been issues with the paperwork.

Staff told us and we saw evidence of training needs analysis to understand the skills required by staff to deliver the service. One manager explained that each year they identified the needs of the service and how many staff

## Are Walk in centres effective?

would be required to have specific training such as prescribing and paediatric skills. Training. Staff told us that they had access to master's course and that each module was evidence based.

We saw examples of training for extended roles e.g. flu vaccinations. The member of staff involved felt that this had allowed her to develop a new skill and be a valued member of the team.

Staff told us that the new approach to block of mandatory training had been welcomed but that some staff had experienced difficulty in accessing the training for resuscitation skills. The service had achieved 87% compliance.

We were shown the competency framework for both qualified and non-qualified staff. This was a very comprehensive programme linked to the core skills required for the provision of care for patients attending the Walk in Centres. This was embedded across the service as part of induction and continued staff development. A manager told us that since an upgrade to the Information system in 2010 they had been unable to carry out detailed peer review audits of the nurse practitioners other than through paper audits of clinical records. This may have an impact on the ability of the service to clearly monitor the effectiveness of the nurse clinicians in their practice.

We were told that the use of agency staff was utilised to accommodate staff shortages. Staff told us where possible the hours were filled by permanent staff to ensure the

continuity of care and appropriate skill mix. The manager told us that they had started to plan for staff to rotate across the Walk in centres but that this was not yet embedded within the service.

Some staff told us that they had access to regular clinical supervision. Not all staff had received supervision although the majority of staff felt that they were well supported by the team and could approach any member of staff for advice and support.

### **Multi-disciplinary working and working with others**

The staff told us that they had close links with other professionals working at the same location such as district nurses or treatment room staff. Staff also told us that they had access to specialist teams such as the safeguarding teams and rapid access team. We found that the "Old Swan" building had a positive sharing culture, working around the patient with all the professionals based in the building with the Walk in Centre.

But, we saw limited evidence of integrated working externally with partners. The clinical staff told us they worked well with the local acute trust for the transfer of ill patients but did not have regular meeting with their primary care colleagues. Individual staff described how they made contact with primary care for specific patients but not in a strategic approach to improve the overall patient journey and develop co-ordinated integrated care pathways.

## Are Walk in centres caring?

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

### Compassionate care

We spoke with over 40 patients during our inspection who told us that they were very happy with the service they received. We received only positive comments about the care and support from the services at the trust.

Staff listened to patients and responded positively to questions and requests for information. One nurse described how they had followed up an elderly patient and had contacted their GP to ensure that they had attended for a follow up appointment.

All staff spoke with pride about their work including those who were working in difficult circumstances.

### Dignity and respect

We saw staff treating people with dignity and respect. Staff maintained privacy by ensuring that doors were closed and knocking before entering a room. Curtains were in place to maintain privacy if someone was undergoing a procedure. We observed that staff spoke with patients respectfully, were open, caring and friendly in their approach.

Patients told us that they had been treated with respect. They told us that the staff looked after their relative very well and explained everything.

### Patient understanding and involvement

Patients we spoke with told us they were fully involved in their care and that they understood what was happening to them and they were involved in planning their own treatment goals.

All of the staff we spoke with were able to describe the process for obtaining consent and records showed examples such as “Patient happy with treatment plan”. Patient in agreement with treatment plan”. One person told us “The staff are very helpful and informative can’t do any more than what they do.”

Records seen were person centred and specific to the individual needs. Staff respected patients’ confidentiality and sought permission to share personal information with other professionals as required.

### Emotional support

Patients told us they felt reassured from the advice and information from the nursing staff at the Walk in centres. Some people told us that this was their second visit to a walk in centre and were confident in the care they had previously received.

### Promotion of self-care

During consultations staff had been aware of the need to promote self-care wherever possible and this was confirmed during our discussions with staff, patients and relatives.

We saw that the service as involved in an initiative “Every Contact Counts ” to promote the use of health promotion interventions such as smoking cessation, oral health and dietary advice.

# Are Walk in centres responsive to people's needs?

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

## Service planning and delivery to meet the needs of different people

Patients arriving at the Walk in Centre were seen by a nurse promptly and triaged according to their needs. We were told that the triage process had been audited to ensure that patients were seen according to need to ensure safe delivery of care.

We were able to observe response times and track individual journeys through the Walk in Centres. We observed that most people were seen promptly and no one we met had been waiting longer than half an hour.

Overall the walks in centres performed well when compared against the England average performance for the key indicators. Data showed that the centres consistently met or exceeded the threshold of 5% set by the department of Health, for re-attendance. The re-attendance rates were important as they may indicate an initial incorrect diagnosis or poor initial treatment.

The staff we spoke with understood their local population and provided a comprehensive assessment of individual needs as part of the consultation process. People told us that they were happy with their treatment and felt that their individual needs and wishes had been met and they had been fully involved in their own treatment plans.

The service was open to anyone with no exclusion criteria. The service philosophy stated that if a patient could not be treated at the Walk in centre they would be signposted to the most appropriate service.

During our inspection we received mixed responses to the co-location of the walk in centre with the sexual health clinics. Some people told us that they felt embarrassed attending the shared waiting area and reception for sexual health as for the walk in centre. Other people were less concerned and felt that it may break down barriers to people attending for sexual health. We did not find evidence of any plans to address the issues or plans for remedial action to ensure people's privacy and confidentiality when attending both services and to ensure that people were seen in a timely manner according to different service needs.

## Access to care as close to home as possible

There were four Walk in Centres located across the geographical area in Liverpool for ease of access to the general population of Liverpool.

## Access to the right care at the right time

The service is open 365 days a year. Opening hours varied across the Walk in Centres most of the centres operated extended hours of opening from 7 am until 10 pm, with Garston Walk in Centre opening from 9am until 9pm.

The manager was able to describe how they identified the skill mix and competences of staff to ensure that staff had been fully trained to meet the patient profile case mix.

We were told that the service tried to manage the varying demands on the service such as before normal working hours and early evenings by using staff rotas and extra staff. Staff told us and incidents reported showed that there had been several occasions this year when staff had initiated the escalation process to get extra staff or had to divert patients to other centres or to return the following day due to high demand and a lack of nursing capacity. This showed us that the service was not always able to be as responsive as it wanted to maintain access to the service.

We were told that information for patients was printed out on an individual basis. However we found little information readily available in different languages or formats such as braille or easy read format in the centres we inspected.

Where people did not speak English staff told us how they could access an interpreter if needed. Staff told us that they also had access to language line if required. On the day of our inspection we met an interpreter who had arrived to translate for a French speaking patient.

In all the centres we visited we found that the buildings lacked clear signage to the Walk in Centre. One patient told us that they found it difficult to find the entrance at the new building in Liverpool and found the shared area between the sexual health service and the walk in centre confusing.

## Meeting the needs of individuals

All the records we reviewed held a comprehensive assessment of both individual medical and nursing needs including ethnic and cultural needs. We were able to

## Are Walk in centres responsive to people's needs?

observe supporting patients with both physical disability and visual impairment. Both patients felt that the staff had been fully aware of their individual needs and had been well supported.

Staff we spoke with were knowledgeable about the Mental Health Capacity Act 2005 (MCA), safeguarding children and vulnerable adults. Where staff suspected abuse we were shown clear pathways for staff to follow as part of the alert process.

### **Moving between services**

The service manager was able to describe steps that had been taken to improve links with the ambulance service after an incident when there was a delay in accessing ambulance transport. The service had developed clear links with the ambulance to ensure that patients could be transferred in a timely manner if they needed urgent transfer to the acute service.

Staff told us that they had close links with the local acute trust and could transfer directly to services as and when required. We observed that at the centre with access to primary care doctors there were close links and staff had easy access to advice and support.

### **Complaints handling (for this service) and learning from feedback**

We found that there had been 144 complaints about the Walk in Centres in the last twelve months.

Staff told us that they did get feedback on complaints but that it was done as individual feedback to complaints or via email as they did not have staff meetings.

The manager was able to monitor complaints via the centralised trust electronic system and was able to identify trends. We were able to track two complaints which had been fully investigated and action plans put in place to learn from the complaint and prevent the reoccurrence of similar issues. The complaints we looked at included concerns such as the timely transfer of information to the patients GP and improvement of a reception area to ensure greater patient privacy.

We saw feedback from the Walk in Centre Patient Experience Survey 2013/2014. Aspects of treatment and care relating to communication, involvement and dignity were highly rated. However a small number of patients stated that they did not have a discussion in a private and confidential surrounding. The majority of respondents were not given written information about their treatment. The manager told us that plans had been put in place to remedy this and ensure that patients receive appropriate information as part of their care plan.



## Are Walk in centre well-led?

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

### Vision and strategy for this service

Some of the staff we spoke with were aware of the trust values but the inspectors received mixed responses to their questions about the trust and its vision and strategy. Some staff were positive that the new interim Chief Executive had been to see them at one of the walk in centres.

Staff we spoke with felt that locally the managers understood their issues but did not feel engaged with senior managers.

Staff in each team were aware of the challenges and key risks to the services they provided.

### Governance, risk management and quality measurement

All the services we inspected had systems in place to monitor their service. Staff performance was reviewed and monitored. We saw that routine audit and monitoring of key processes took place such as waiting times, incidents and complaints. Mandatory training was closely monitored in addition to sickness absence and staffing levels.

The walk in centres were monitored through the Department of Health Clinical Quality Indicators for Accident and Emergency Departments such as re-attendance rates and four hour waiting times. The local managers were aware of the commissioner contracts and had access to detailed in-house data on key performance indicators through the trust web based performance system (OPERA).

The service had representation at a directorate monthly clinical governance meeting where they reviewed all incidents. This committee also reviewed relevant national guidance published each quarter to ensure that they were assessing themselves in line with appropriate current national standards.

### Leadership of this service

Staff were aware who their manager was. Staff felt that they had clear management structures in place and were encouraged by both the service manager and clinical

managers. The staff we spoke with told us they received good support from their line managers. One person told us “The manager does their best and tries to get us more staff.”

### Culture within this service

We found highly motivated and committed staff in their job roles. However we found that they were very tired after working extra hours to cover staff shortages.

We met a clinical workforce who was committed to the care of their patients and the development of their profession and job roles. However despite some good examples of working with the higher education establishments we found that the service was not engaged with other networks or national groups to share best practice and drive service improvements. The lack of clinical engagement with primary care colleagues may impact on the ability of the service to develop innovative practice.

### Public and staff engagement

There was patient engagement as part of individual treatment and care planning. Staff told us that they valued the regular staff surveys and felt confident to respond. The latest 2013 staff survey showed that for 11 indicators the trust performed worse than average. The majority of staff we spoke with told us they had good access to training however staff told us that the lack of staff to back fill vacancies had impacted on their ability to attend some postgraduate training. One of the lowest performance indicators was that staff felt under pressure to attend work when feeling unwell.

We were told that the service had recommenced the Patient Champion meetings to review the patient's journey. However we were told that they had not yet been able to get patient participation on the group to allow the service to fully plan services with the patient at the centre of service delivery.

### Innovation, improvement and sustainability

We found that the lack of regular staff meetings and staff capacity may impact on the staff having the opportunity to discuss areas for improvement and innovation. Although

## Are Walk in centre well-led?

the accreditation by the local university for a training course on minor injuries was recognised as good practice the inspectors did not find evidence of strategic plans to drive innovation and improvement.

The manager told us that the new information system would assist in the auditing, monitoring and reviewing of service delivery which would help to plan for service improvement and innovation.