Walk in 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	Requires improvement
Are services safe?	Requires improvement
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 the Walk in Centre, Dewsbury and District Hospital on 23 February 2017. Overall the centre is rated as requires improvement.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Although some risks to patients were assessed, we found a lack of written protocols to support verbal agreements between the Walk in Centre and Mid Yorkshire Hospitals Trust (MYHT) which would clarify the arrangements and responsibility for the assessment, monitoring and management of the area and the reduction of risks to patients' safety.
- The provider could not assure themselves that locum staff from the agency were Disclosure and Barring Service (DBS) checked or had suitable indemnity arrangements in place. (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).
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results showed that between February 2016 and February 2017 of 854 responses, 92% of patients would be likely or extremely likely to recommend the service to their friends and family. The service had not undertaken a patient survey.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The service could not evidence ongoing clinical audits or demonstrate quality improvement.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff.

Summary of findings

- The provider was aware of the requirements of the duty of candour and there was a staff information booklet to support this. Staff were knowledgeable about this issue.
- Children under 12 months were directed to the emergency department and not seen in the walk in centre. However, a flow chart developed by the service and MYHT stated that children aged two or more could be directed to the walk in centre and it did not detail the pathway for children between 12 months and two years old. We were told there was another protocol for this age group but we did not see this on the day of inspection.

The areas where the provider must make improvement are:

- Introduce a system to assure themselves that all appropriate checks have been carried out by the employing agency on any locum staff used.
- The provider must be able to demonstrate clinical audits and assure themselves that they have considered the quality of care provided, reviewed the care provided in relation to current best practice guidance and made changes where necessary in order to improve.
- The service must be able to assure themselves of the arrangements and responsibility for the assessment, monitoring and management of the area and the reduction of risks to patients' safety within the walk in centre.

The areas where the provider should make improvement are:

- The service should clarify the arrangements for the initial review of children aged between 12 months and two years of age and ensure that the joint protocol for assessment between MYHT and the Walk in Centre reflects this.

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?

Requires improvement

The service is rated as requires improvement for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the service. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- Although some risks to patients were assessed, we found a lack of written protocols and agreements between the Walk in Centre and Mid Yorkshire Hospitals Trust (MYHT) which would clarify the arrangements and responsibility for the assessment, monitoring and management of the area and the reduction of risks to patients' safety.
- The service could not evidence a policy or a risk assessment which detailed the types and amounts of high risk medicines that were agreed as appropriate for clinicians to prescribe.
- We saw that the centre had arrangements to respond to emergencies and major incidents. The service were not responsible for checking emergency equipment such as defibrillators and emergency medicines, this was the responsibility of MYHT.
- We saw that the service had a fire risk assessment and an evacuation profile which would help staff to evacuate patients. We were told the service had not been included in fire drills that were led by MYHT.
- The provider could not assure themselves that locums from the agency were DBS checked or had suitable professional indemnity arrangements in place. We were told this was the responsibility of the agency to check these points.

Are services effective?

Good

The service is rated as good for providing effective services.

- Staff were aware of current evidence based guidance.

Summary of findings

- The service could not evidence ongoing clinical audits or demonstrate quality improvement activity. The service had audited antibiotic prescribing and some patient notes. On the day of inspection we did not see that following these audits a plan was in place to improve patient care moving forward.The service had already identified this as an area that required improvement.
- The Friends and Family test is a feedback tool which asks people if they would recommend the services they have used to their friends and family. Data between February 2016 and February 2017 showed that of 854 responses, 92% of patients would be likely or extremely likely to recommend the service to their friends and family.
- The service planned to undertake a patient survey in April 2017.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. Due to the situation of the centre the staff had immediate access to emergency department practitioners if they were required.

Are services caring?

Good

The service is rated as good for providing caring services.

- Data from the Patient Opinion website, the friends and family test survey and comments gathered through the CQC patient comment cards showed that patients felt they were treated with compassion, dignity and respect.
- Information for patients about the service available was accessible and interpreters were available.
- We were told of examples where staff would liaise with GP services on behalf of patients who had struggled to see their GP to ask for emergency appointments on their behalf.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality where possible. The bays where patient consultations were held were divided by curtains only, staff were aware that this could impact on the dignity, privacy and confidentiality of the patient consultation and did what they could to avoid patients being viewed by others or conversations overheard.
- The centre had a number of trained and Disclosure and Barring Service (DBS) checked volunteers who assisted patients whilst they were in the centre and orientated them around the

Summary of findings

building. We observed volunteers giving information about waiting times and generally supporting patients in a caring manner. The volunteer we spoke with felt very supported by the staff and provider.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- The service understood its population profile and had used this understanding to meet the needs of its population. The service had increased the number of practitioners working on bank holidays to respond to the increase in demand at these times.
- The Walk in Centre was open every day of the year. It was open between 9.00am and 8pm Monday to Friday and between 10am and 6pm on a Saturday, Sunday and bank holidays. After these times patients who needed to be seen would be directed to the emergency department or to their own GP as appropriate.
- Patients we spoke with said they found the service accessible with clear information around waiting times.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from five examples reviewed showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

The service had developed a leaflet in English to inform patients of the purpose of the Walk in Centre, how to use the service and who they might see.

Are services well-led?

Requires improvement

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

- The service had some systems and processes in place and an overarching governance framework, however we found this was not always operating effectively. For example, we found a lack of written protocols to support verbal agreements between the Walk in Centre and Mid Yorkshire Hospitals Trust (MYHT) which would support staff and clarify the arrangements and responsibility for the assessment, monitoring and management of the area and the reduction of risks to patients' safety.
- We saw evidence of basic audits such as antibiotic prescribing but we did not see evidence that this information was used to monitor quality or to make improvements to patient care.
- Service specific policies were implemented and were available to all staff. However, some policies such as the business

continuity plan did not contain practical telephone numbers which could be accessed quickly in an emergency. The plan was dated September 2016 and was noted to be undergoing external scrutiny at that time.

- A basic understanding of the performance of the service was maintained and staff were aware that they were meeting the targets set by North Kirklees clinical commissioning group.
- Staff had received inductions, annual performance reviews were encouraged to attend staff meetings and training opportunities. The frequency of staff meetings had recently been increased to monthly to improve communication within the team and we saw examples where feedback had been acted on. For example, an induction pack for the Walk in Centre had been developed by a member of staff.
- We saw that the provider had recently introduced a monthly newsletter for all staff which included training courses, safeguarding information, updates of incidents and general service feedback.
- The provider was aware of the requirements of the duty of candour and there was a staff information booklet to support this.
- The provider encouraged a culture of openness and honesty. The service had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The service encouraged patients to complete the Friends and Family test survey and planned to carry out a patient survey in April 2017.

Summary of findings

What people who use the service say

As part of our inspection we asked patients who attended the walk in centre to complete a CQC comment card prior to our inspection. We received 23 comment cards, of which 21 were very positive about the standard of care received. Numerous patients who completed the cards described the service as excellent or first class and commented on the care, knowledge and professionalism of the staff. One patient said they had waited four hours to be seen and one card contained both positive and negative comments.

We spoke with two patients during the inspection who were happy with the service provided. One patient had used the service on several occasions and said the reception staff were polite and the staff knowledgeable.

The Friends and Family test is a feedback tool which asks people if they would recommend the services they have used to their friends and family.

Results showed that between February 2016 and February 2017 of 854 responses, 92% of patients would be likely or extremely likely to recommend the service to their friends and family.

The Walk in centre also encourages patients to leave comments on the 'Patient Opinion' website. (https://www.patientopinion.org.uk/opinions). We reviewed comments which related to the Walk in Centre over the last 7 months and these were positive about the staff and care given.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvement are:

- Introduce a system to assure themselves that all appropriate checks have been carried out by the employing agency on any locum staff used.
- The provider must be able to demonstrate clinical audits and assure themselves that they have considered the quality of care provided, reviewed the care provided in relation to current best practice guidance and made changes where necessary in order to improve.
- The service must be able to assure themselves of the arrangements and responsibility for the assessment, monitoring and management of the area and the reduction of risks to patients' safety within the walk in centre.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The service should clarify the arrangements for the initial review of children aged between 12 months and two years of age and ensure that the joint protocol for assessment between MYHT and the Walk in Centre reflects this.

Walk in 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 further CQC inspectors.

Background to Walk in Centre

The Walk in Centre is situated within the emergency department of Dewsbury and District hospital, Halifax Road, Dewsbury, West Yorkshire, WF13 4HS.

The service is an NHS walk-in centre, commissioned by North Kirklees Clinical Commissioning group (CCG) and provides routine and urgent primary care for minor ailments and injuries with no requirement for patients to pre-book an appointment or to be registered at the centre or with a GP practice. The centre is described as a 'see and treat service', and this service is offered to everyone. However, the centre does not offer a service to children under 12 months old or women with pregnancy related issues.

The Walk in Centre is located within an area of the emergency department and consists of four curtained bays and a small open desk adjacent to this area. There is also a small dedicated area for children. Staff consult with patients within the bays and access patient notes using mobile computer workstations. During busy periods the bays allocated to the Walk in Centre could be used by the emergency department and the walk in staff could see patients within the children's area. The waiting room and reception area are shared with the emergency department. There is level access and disabled facilities with car parking available within the hospital grounds.

The centre is open every day of the year. It is open between 9.00am and 8pm Monday to Friday and between 10am and 6pm on a Saturday, Sunday and bank holidays.

Kirklees has an ethnically diverse population with 21% of residents noting their ethnicity to be non-White in the 2011 Census. The largest group is people of south Asian origin at 15%.

The Walk in Centre employs a male modern matron who is the clinical lead, one male community nurse, two reception staff, a reception officer, five female specialist nurse practitioners and two paramedics/ emergency care practitioners who work full and part time hours.

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 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 Walk in Centre and asked other organisations including NHS England and North Kirklees Clinical Commissioning Group (CCG) to share what they knew about the Walk in Centre. We reviewed relevant information

Detailed findings

the Walk in Centre provided before, during and after the inspection. We also reviewed data from the NHS Friends and Family Test (FFT). We carried out an announced visit on 23 February 2017. During our visit we:

- Spoke with a range of staff including the centre matron, several members of the providers' management team (who do not work on site), a member of the admin team; a permanent advanced nurse practitioner (ANP), a bank staff ANP, a locum ANP and an emergency care practitioner.
- Spoke with two patients who used the service.
- Observed how patients were being cared for in the treatment area.
- Reviewed a small sample of the personal care or treatment records of patients.
- Reviewed 23 comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at the available information the service used to deliver care.

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?

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the centre matron of any incidents and there was a recording form available on the computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (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 reviewed one example when things went wrong with care and treatment. The patient, whilst not the subject of the incident, was informed as soon as reasonably practicable.
- We reviewed safety records, incident reports, patient safety alerts, a newsletter and minutes of meetings where significant events were discussed. The provider carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the Walk in Centre. For example, numerous incidents regarding technology had been reported over the last 12 months and the provider had identified this as a high risk area and action had been taken to address access and connectivity.
- The service also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Although risks to patients were assessed, we found a lack of written protocols and agreements between the Walk in Centre and Mid Yorkshire Hospitals Trust (MYHT) which would clarify the arrangements and responsibility for the assessment, monitoring and reduction of risks to patients' safety.
- We saw that the centre had arrangements to respond to emergencies and major incidents. The service were not responsible for checking emergency equipment such as defibrillators and emergency medicines, this was the responsibility of MYHT. After the inspection an agreed draft protocol was forwarded to us.
- We saw that the service had a fire risk assessment and an evacuation profile which would help staff to evacuate patients. We were told the service had not been included in fire drills that were led by MYHT.
- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare by means of a flow chart and further information was available on the provider intranet safeguarding page. There was a newly allocated lead member of staff for safeguarding and we saw that staff were trained to level two or three. We also saw that safeguarding issues and any referrals were discussed and reviewed at clinical meetings to ensure best practice had been followed.
- A notice in the treatment bays and waiting area advised patients that chaperones were available if required. All staff who acted as chaperones were clinicians and had received a Disclosure and Barring Service (DBS) check. (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). We were told that the clinician carrying out the consultation would update the patient notes.

The service maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. We were assured that there were cleaning schedules and monitoring systems in place which were led by MYHT and the lead matron told us that random undocumented checks were undertaken. Following our inspection we were sent copies of the cleaning checklist for the toys that patients who used the Walk in centre had access to and COSHH (Control of Substances Hazardous to Health) risk assessments and data sheets.
- The provider had a quality lead for infection prevention and control (IPC) who liaised with the local lead to ensure that best practice was followed. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example we saw that eye protection was made available to staff as a result of the audit and that issues relating to the estate where referred to MYHT.

Requires improvement

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, were managed by verbal agreement with the MYHT at the time of our inspection and these agreements aimed to reduce risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- The non-medical prescribers at the centre told us that only small amounts of high risk medications were prescribed to patients, in some cases a supply of only one or two tablets, to reduce risk to patients. (A Non-Medical Prescriber is a health professional who is not a doctor who is able to able to prescribe medicines, dressings and appliances.) We did not see a protocol which supported this practice or detailed the amounts or types of medications involved.
- The service had carried out an audit regarding the provision of antibiotics by practitioners but we did not see any detail of how this would be reviewed or monitored moving forward.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions (PGDs) had been adopted by the centre to allow nurses who were not prescribers to supply and administer medicines in line with legislation. These were the same PGDs that were used by MYHT, following the MYHT PGD policy with input from the provider. Stock of any medications used against a PGD were managed by MYHT.
- The service had access to a stock of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and we were told that staff would follow MYHT procedures to manage them safely. These medicines could only be accessed in the presence of a MYHT member of staff. Arrangements for the destruction of controlled drugs, sharps and pharmaceutical waste were managed by MYHT. Following our inspection a medicines management arrangement between the provider and MYHT was formulated and forwarded to the CQC.

We reviewed four personnel files of permanent members of staff and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However, there was no system in place for the provider to assure themselves that all appropriate checks had been carried out by the employing agency on locum staff used.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The provider regularly reviewed a Key Opportunities, Risks and Successes document which aimed to identify, review and reduce areas of risk of harm.
- The service had an up to date fire risk assessment but we did not see evidence that the majority of risks identified in this document had been acted upon. However, numerous actions involved the service waiting for a response from MYHT. We were told the service had not been included in fire drills that were led by MYHT. There were designated fire marshals within the service. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. The checking of this equipment was arranged by MYHT.
- The service had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. However, we saw that at times due to the skill mix of the staff, the team on duty did not always include staff who were able to request x-rays of limbs or prescribe medications. We were told that there was an agreement with the emergency department as to how patients would be managed at these times.

Arrangements to deal with emergencies and major incidents

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

Requires improvement

Are services safe?

- There was an instant messaging system in the area which alerted staff to any emergency. Staff were also able to call on the support of the emergency department staff when needed.
- All staff received annual basic life support training and there were emergency medicines available.
- The service had access to a defibrillator on the premises and oxygen with adult and children's masks. All other items of first aid equipment and an accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the emergency department, however one member of locum staff told us that they did not know where these were kept. All the medicines we checked were in date and stored securely.
- The service had a comprehensive business continuity plan for major incidents such as unprecedented patient demand, power failure or building damage. The plan included emergency contact numbers for staff. However, it did not contain a contact number for the provider or for utility services. We saw that the plan was dated September 2016 and was noted to be undergoing external scrutiny at that time.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The service had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and told us that they used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The service produced monthly monitoring reports of the activity undertaken and the services delivered. This information was shared with the Clinical Commissioning Group (CCG) and Key Performance Indicators (KPIs) had been agreed with the CCG. The agreed targets were:

- 95% of patients should be seen and treated within four hours. We saw evidence that between April 2016 and December 2016 the service exceeded this target and achieved between 99%-100%.
- Less than 5% of patients should leave the centre without being seen. We saw that between April 2016 and December 2016 the service could evidence that between only 1% and 3% of patients who registered with the service left without being seen.
- The target for re-attendance should be below 5%. We saw that between April 2016 and December 2016 the re-attendance rate was between 2%-4%.
- Between April 2016 and December 2016 the walk in centre saw 10,101 patients, an average of 1,122 patients per month which was comparable to previous years.

When patients attended the Walk in Centre their attendance was documented by clinicians on two separate recording systems, the emergency department clinical computer system and a different clinical computer system often used in GP practices. When patients were discharged from the service the documentation on the emergency department system would generate a discharge letter for the patients' GP to update them of the patients' attendance.

We did not see evidence of quality improvement driven by clinical audit:

- There had been an audit of anti-biotic prescribing undertaken but we did not see that a plan was in place to re-audit this or that action had been taken. We also saw that a records audit had been undertaken but we did not see an action plan arising from this. The service shared with us that they planned to commence clinical audits. The lack of audits had been identified as an area which required improvement by the organisation.
- A medicines inspection which was undertaken by the provider prior to our inspection stated that 'each service should have a system of standard operating procedures (SOPs) covering each of the activities concerned with medicines to ensure the safety and security of medicines stored and used in it'. The report stated that no SOPs relating to medicines were in place.
- We saw evidence of an infection control audit and a handwashing audit and that actions had been taken as a result of these.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The provider had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff. For example, training was supported for staff to enhance their skills and become non-medical prescribers. We were told that this also led to a high turnover of staff as once they were trained they moved to new roles elsewhere.
- Regular locum staff were used at the Walk in Centre and we were told an induction was in place to support locums. A small information card had been developed to aid communication whilst working at the centre. All locums were provided with guest access to the computer systems.
- The learning needs of staff were identified through a system of appraisals and meetings. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring,

Good

Are services effective?

(for example, treatment is effective)

clinical supervision and facilitation and support for revalidating nurses. All staff currently working at the service had received an appraisal within the last 12 months.

- 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. We were told that staff were trained to level two or three. The provider had experienced problems with the IT system for accessing and recording safeguarding training. We saw evidence that this was being managed in a monthly newsletter and in the interim staff had been asked to complete the training available within their personal computer records, review documents and attend meetings.

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 centre's patient record system and their intranet system.

- The Walk in centre had access to two clinical computer systems which enabled them to review patient notes if they were registered with a GP or had attended the emergency department previously.
- For patients who were not registered with a GP we saw that a document had been produced to assist staff to complete suitable identification checks where possible.
- We saw that the service used the clinical systems to share relevant information and patients were referred to other services such as ophthalmology or audiology services when necessary.
- We were told that all children under 12 months were directed to the emergency department and not seen in the walk in centre. However, a flow chart developed by the service stated that children aged two or more could be directed to the walk in centre and it did not detail the pathway for children between 12 months and two years old. We were told there was another protocol for this age group but we did not see this on the day of inspection.

Staff worked together and with other health professionals including clinicians within the emergency department to understand and meet the range and complexity of patients' needs and to assess and plan immediate care and treatment. If a patient deteriorated or required additional care whilst registered with the Walk in Centre, there was a verbal agreement in place that they would be transferred and seen by clinicians in the emergency department.

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, including the Mental Capacity Act 2005.
- The service would assess the capacity of young people under the age of 18 who attended the centre without a parent, using the Gillick competency and Fraser guidelines. (This guidance helps to balance children's rights and wishes with the responsibility to keep children safe from harm).
- Where a patient's mental capacity to consent to care or treatment was unclear the service staff told us they would assess the patient's capacity and record the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with kindness, dignity and respect.

- The bays where patient consultations were held were divided by curtains only. Staff were aware that this could impact on the dignity, privacy and confidentiality of the patient consultation and did what they could to avoid patients being viewed by others or conversations overheard. We saw that firm plans were in place to move the Walk in Centre to another area of the emergency department and that during this refurbishment two cubicles with doors would be provided.
- Patients could be treated by a clinician of the same sex.
- The service had a number of trained and Disclosure and Barring Service (DBS) checked volunteers who assisted patients whilst they were in the centre and orientated them around the building. We observed volunteers giving information about waiting times and generally supporting patients in a caring manner. The volunteer we spoke with felt very supported by the staff and provider.
- Patients would be called individually by clinicians who would walk with them to the treatment area.

We received 23 Care Quality Commission comment cards, of which 21 were very positive about the standard of care received. Numerous patients who completed the cards commented that staff were caring and considerate and that the centre provided a very good service.

We spoke with two patients during the inspection who told us that they were using the service as they had been unable to get appointments with their GP and that they were told clearly how long they would need to wait.

Care planning and involvement in decisions about care and treatment

Information from the patient comment cards told us that patients felt involved in decision making about the care and treatment they received. They also told us 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.

Children and young people were treated in an age-appropriate way and recognised as individuals. There was a clearly defined space for children to wait with toys and a television. This space was further away from the emergency department than the rest of the centre and so would reduce the likelihood of children witnessing distressing scenes.

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that telephone interpretation services were available for patients who did not have English as a first language. We saw that the receptionist would make patients aware of this service when they registered.
- Information leaflets detailing the service were available, but these were only in English. Information was displayed about the waiting times and we saw that reception staff would also make patients aware of this when they registered.
- We were told that clinicians saw approximately three patients per hour and spent time involving patients in decisions about their care and treatment.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients what to expect from the service and how long they would wait. Volunteers were also on hand to answer questions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service understood the needs of the local population and had used this understanding to begin to tailor services to meet their needs.

- The service had increased the number of practitioners working on bank holidays to respond to the increase in demand at these times.
- Patients we spoke with said they found the service accessible with clear information around waiting times.
- The service had developed a leaflet in English to inform patients of the purpose of the Walk in Centre, how to use the service and who they might see.
- The service allocated approximately 20 minutes per appointment to meet individual needs.
- The service had accessible facilities and was wheelchair friendly.
- Patients could be treated by a clinician of the same sex.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The service had considered the NHS England Accessible Information Standard. Much of the information given within the centre was verbal.

Access to the service

The Walk in Centre is open every day of the year. It is open between 9am and 8pm Monday to Friday and between 10am and 6pm on a Saturday, Sunday and bank holidays. After these times patients who needed to be seen would be directed to the emergency department or to their own GP as appropriate.

- The opening times for the centre were advertised locally and on the internet.
- Patients were not triaged at reception but were seen in order of arrival. We were told that no further assessment of the patient was undertaken. Patients who did not meet the criteria to be seen at the Walk in Centre, as detailed by a flow-chart, were signposted to the emergency department.
- Patient comment cards did not highlight any concerns regarding accessibility to the service.

Listening and learning from compliments, concerns and complaints.

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

- We saw that complaints were managed in line with recognised guidance and contractual obligations. The complaints policy did not detail that complaints would be responded to within three days of the service receiving the complaint but this was noted in the complaints leaflet for patients.
- There was a designated responsible person who handled all complaints at the centre.
- We saw that an information leaflet was available to patients from the reception to help patients understand the complaints system.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. We saw that lessons were learned as a result of complaints and that action was taken to prevent the same thing happening again including internal investigations when necessary. We saw that patients received an explanation and an apology where appropriate. We saw evidence that these were reviewed at clinical meetings.

We saw that the service had received two compliments from patients in the last 12 months. Patients commented on the care and attention given to them and that staff were very skilled in clinical assessment and communication.

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 provider had a mission statement and staff knew and understood the values. The values included a commitment to the population, to be caring, provide a quality service and invest in technology.
- The service had a strategy and we saw that a patient engagement plan was in place. The present contract had been awarded for 12 months which had caused some uncertainty within the team.

Governance arrangements

The service had an overarching governance framework, however we found this was not always operating effectively. For example,

- We saw evidence of basic audits but we did not see evidence that this information was used to monitor quality or to make improvements to patient care. There had been an audit of anti-biotic prescribing undertaken but we did not see that a plan was in place to re-audit this or that action had been taken. We also saw that a records audit had been undertaken but we did not see an action plan arising from this. The service shared with us that they planned to commence clinical audits. The lack of audits had been identified as a risk by the organisation.
- A medicines inspection which was undertaken by the provider prior to our inspection stated 'each service should have a system of standard operating procedures (SOPs) covering each of the activities concerned with medicines to ensure the safety and security of medicines stored and used in it'. The report stated that no SOPs relating to medicines were in place.
- We saw evidence of an infection control audit and a handwashing audit and that actions had been taken as a result of these.
- On the day of inspection we were not assured that there were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Although some risks to patients were assessed, we found a lack of written protocols to support verbal agreements between the Walk in Centre and Mid Yorkshire Hospitals Trust (MYHT) which would clarify the arrangements and responsibility for the assessment, monitoring and management of the area and the reduction of risks to patients' safety.
- Service specific policies were implemented and were available to all staff. These were updated and reviewed regularly. However, some policies such as the business continuity plan did not contain practical telephone numbers which could be accessed quickly in an emergency. This policy was dated September 2016 and was noted to be undergoing external scrutiny at that time.
- There was a staffing structure and that staff were aware of their own roles and responsibilities. The staff within the Walk in Centre were supported by a provider management team who led in key areas such as infection prevention and control, quality and complaints.
- A basic understanding of the performance of the service was maintained and staff were aware that they were meeting the targets set by North Kirklees clinical commissioning group. Clinical meetings were held monthly which provided an opportunity for staff to learn about the performance of the service, this had recently been increased from quarterly and we were told that monthly meetings would continue.
- A monthly newsletter had been introduced in February 2017 to keep staff informed and share news, feedback important information and alert staff to training dates.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Staff were proactively encouraged to document concerns and complaints.

Leadership and culture

Staff told us they prioritised safe, high quality and compassionate care. However, we were not assured that this was fully supported by protocols and agreements as to how patients were treated and managed including written agreements as to the amount of medications that would be prescribed.

- The provider offered attendance at a wellbeing group for staff and they could also apply to a wellbeing fund

Are services well-led?

Requires improvement

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

for monies for items such as staff away days and microwaves for staff areas. Staff could also be referred to mindfulness sessions, sleep seminars, counselling and physiotherapy.
- Staff told us the management team were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (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).This included support training for all staff on communicating with patients about notifiable safety incidents and we saw that a booklet had been developed for staff to help them understand the requirements.

The provider encouraged and promoted a culture of openness and honesty. From a sample of 13 documented significant events from the last 12 months we found that only one related to clinical care. We found that the staff member who was put at risk was supported to attend occupational health and advised on the way forward. The patient was also made aware. Most of the issues reported related to clinical systems and IT issues.

When complaints were received, we found that the service had systems to ensure that when things went wrong:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- The provider kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff told us that they felt supported by management.

- The service had recently implemented monthly clinical meetings and we saw evidence of one full team meeting within 12 months. Staff were also supported by regular email communication and a recently introduced newsletter.
- When meetings were held we saw evidence that safeguarding concerns were discussed and staff told us that they were reviewed in detail to ensure that the right action had been taken.
- Staff told us there was an open culture within the centre and at provider level and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for staff to view.
- Staff said they felt respected, valued and supported, by the provider and each other. All staff were involved in discussions about how to run and develop the service, and the provider encouraged all members of staff to identify opportunities to improve the service delivered.

Seeking and acting on feedback from patients, the public and staff

The service encouraged and valued feedback from patients and staff.

- The provider had not conducted a patient survey to ascertain the views of the population using their service but we were told that a plan was in place to complete this in April 2017. The service used feedback obtained from the NHS Friends and Family test to judge their performance and fed this back to the CCG. The Walk in Centre also used the Patient Opinion website and encouraged their patients to leave reviews of the service on the site. However, we observed that patients often confused the Walk in Centre and the emergency department and the reviews left were not always valid.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run. One member of staff had been encouraged to improve the staff induction booklet after her own induction to the service.

Continuous improvement

The provider told us that they had plans to consider involving a pharmacist in the support of the centre.

The provider was also considering the implementation of telephone triage and they were looking to review the skill mix of staff.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, and improve the quality and safety of the services provided. They had failed to identify the risks associated with a lack of ongoing clinical audits and could not demonstrate quality improvement. There was no system in place for the provider to assure themselves that all appropriate checks had been carried out by the employing agency on locum staff used. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.