West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre

Quality Report

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Date of inspection visit: 26 October 2017
Date of publication: 11/12/2017

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.

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre on 21 March 2017, and we found a number of breaches of legal requirements. As a result, we issued two warning notices in relation to:

- Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safe care and treatment.
- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Good governance

We also issued a requirement notice in relation to:

- Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Fit and proper persons employed.

After the comprehensive inspection, the service was rated as inadequate overall.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 26 October 2017 to confirm that the service had taken appropriate action to meet the legal requirements in relation to the warning notices issued in July 2017. This report covers our findings in relation to the warning notices only and does not change the existing ratings. We will carry out a further comprehensive inspection in due course at which time we will review the current Inadequate rating.

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

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Practices had been reviewed and systems improved to ensure risks to patients were assessed and well managed.
- Improvements had been made to ensure most patients' care needs were assessed in a timely manner, however gaps were identified and further improvements were needed to ensure the safety of all patients who used the centre.
- Systems had been introduced to ensure all staff could access up-to-date evidence based guidance.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- There was a clear leadership structure and staff felt supported by management.
- Plans were in place to ensure that appropriate staff would be trained and competent to deliver effective care and treatment at appropriate levels to paediatrics (care of children).

The areas where the provider should make improvements are:

- Ensure that the plans for ensuring that staff providing care to children are competent and appropriately trained are followed through.
- Ensure that all policies and procedures introduced are working documents and embedded within the organisation.
- Ensure that effective systems are put in place to monitor patient waiting times.

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

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

Ensure that the plans for ensuring that staff providing care to children are competent and appropriately trained are followed through.

Ensure that all policies and procedures introduced are working documents and embedded within the organisation.

Ensure that effective systems are put in place to monitor patient waiting times.

West Midlands Doctors Urgent Care - Wolverhampton Urgent Care 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 a second CQC inspector.

Background to West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre

West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre (WUCC) is part of theVocare group, which began in 1996 in the North East of England as a co-operative of local GPs providing healthcare to local people. Vocare Limited is a private limited company. WUCC has been operating since April 2016 and is commissioned by NHS Wolverhampton CCG under a single contract to provide an integrated approach to urgent health care, which include all the elements of out of hours (OOHs), urgent care and walk-in services from one location. The services are organised and delivered in a co-ordinated way.

Policies and protocols cover all services and the provider Vocare provides centralised governance for its services, which are co-ordinated locally by service managers and senior clinicians.

WUCC is located on the first floor of the Urgent and Emergency Care Centre at New Cross Hospital, Wolverhampton. An integrated model of urgent health services is available for the whole of Wolverhampton (Population, 262,000). WUCC provides services to one of the less deprived areas of the West Midlands. People living in more deprived areas tend to have a greater need for health services. There is a lower practice value for income deprivation affecting children and older people in comparison to the practice average across England. The OOHs service is extended to patients registered at seven named practices in Seisdon:

- Claverley Surgery
- Dale Medical Practice
- Featherstone Family Health Centre
- Lakeside Medical Centre
- Moss Grove Surgery
- Russell House Surgery
- Tamar Medical Centre

WUCC is led by a local clinical director, operations manager, and a clinical support manager who have oversight of the out of hours (OOHs), urgent care and walk-in services. WUCC is open 24 hours a day, seven days a

Detailed findings

week for people who walk in, or are referred following contact with the NHS 111service. The services provided include an out of hours service between the hours of 5.30pm and 9am on weekdays and 24 hours a day at weekends and bank holidays. All services are provided from one location. WUCC provides access to patients to the services in the following ways:

- Walk-in, any patient can walk directly into WUCC and ask to be seen. These patients are asked to complete a form for themselves or their child by non-clinical staff at the reception desk. The form is handed back to reception staff who document the patients' responses. Patients' names are then entered onto the patient list without a clinical assessment or timed appointment given.
- Following contact with the NHS 111 service and an initial telephone assessment, patients could be given an appointment to attend WUCC or receive a home visit from a GP as part of the OOHs.
- WUCC forms part of the urgent and emergency care centre at New Cross Hospital and is commissioned to provide treatment for minor injuries and illness for patients who do not require A&E treatment but who cannot wait until the next available appointment with their registered GP. Patients within this category undergo a triage assessment by a nurse employed by WUCC or a nurse employed by the hospital and, if clinically assessed as appropriate, are given an appointment to attend WUCC.

All patients are entered onto a single patient list, which includes the walk-in patients who have no timed appointment. All the services are staffed by the same group of doctors, nurses and reception staff. This includes the GP on shift who carries out home visits during the period when the patients' registered GPs are closed.

There are a total of 95 staff working at WUCC. This number includes sessional GPs who are self- employed contractors. The organisational structure at WUCC include a Regional Director, an Assistant Regional Director, a Local Clinical Director and a Clinical Support Manager. Other staff roles include:

- 1 Salaried GP (Also has the role of the Local Clinical Director)
- 29 Sessional GPs
- 1 Clinical Support Manager
- 4 Advanced Nurse Practitioners
- 1 Emergency Care Practitioner
- 3 Nurse Practitioners
- 2 Junior Nurse Practitioners
- 1 Healthcare Assistant
- 9 Drivers
- 14 Receptionists
- 1 Senior Team Leader
- 3 Team Leaders

Why we carried out this inspection

We previously undertook a comprehensive inspection at West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre on 21 March 2017, under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate overall. We took enforcement action against the provider (Vocare) by issuing two warning notices to tell them that services must be improved. The full comprehensive report following the inspection on 21 March 2017 can be found by selecting the 'all reports' link for West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre on our website at www.cqc.org.uk.

How we carried out this inspection

We carried out a focused inspection of West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre on 26 October 2017. This inspection was carried out to ensure that the provider had met the requirements of the warning notices issued to them under the Health and Social Care Act 2008.

During our visit we:

- Spoke with members of the management team at West Midlands Doctors Urgent Care – Wolverhampton Urgent Care Centre.
- Spoke with other staff, who included administration staff, receptionists and advanced nurse practitioners
- Visited the Urgent Care Centre.
- Looked at information the Urgent Care Centre used to deliver safe care and treatment.
- Looked at other relevant documentation.

Detailed findings

Please note that when referring to information throughout this report, for example, any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

During our inspection in March 2017 we found:

- There were no assurances to demonstrate all safety alerts were acted on at a local level.
- There were no assurances to demonstrate that learning from incidents were shared with staff at a local level and staff we spoke with demonstrated a lack of awareness of incidents that had occurred.
- An effective system was not in place to demonstrate that all alerts issued by the
- Medicines and Healthcare Regulatory Agency about medicines were acted on.
- There was an inconsistent approach to the management of children who attended the centre, which could potentially lead to young patients (children) waiting for long periods.
- There was a lack of systems for the safe triage of walk in patients, who were not given an appointment.
- Safe recruitment procedures were not consistently adhered to.

At our previous inspection in March 2017 we found that West Midlands Doctors Urgent Care - Wolverhampton Urgent Care Centre (WUCC) could not be sure that staff would not feel prohibited from appropriately reporting incidents, which included complaints or that incidents were accurately recorded. At this visit, we found that the system for reporting and recording significant events had been reviewed. Improvements made ensured the system in place covered all events that occurred throughout the integrated urgent health care services of out of hours (OOHs), urgent care and walk-in services provided.

- Records we looked at showed that improvements had been made in recording significant events. Staff told us they could inform the team leader or service manager of any incidents and had no concerns about reporting incidents. All staff could report significant events, and could enter the information onto a shared electronic system, or use an appropriate paper form if access to the electronic system was not available. 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 saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support; an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- At the previous inspection we found that the outcome of significant events was discussed and shared with the management team at a regional level, but there were no assurances to demonstrate learning from incidents was shared with staff at a local level. At this inspection we saw that the service carried out a thorough analysis of significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes. Regular staff meetings and a monthly newsletter ensured that learning had been discussed and shared with staff at a local level. There had been 14 significant events recorded since the last inspection. We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, an investigation into the loss of a folder which contained a batch of purple and green hand written prescriptions resulted in a positive outcome in that the folder was found. Verbal and written communication reminded clinical staff of the prescription handling procedures and individual accountability of clinicians who prescribed.
- Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts were managed centrally by the Head of Assurance for Vocare. At the previous inspection we found that there were no assurances to demonstrate all alerts were acted on or searches undertaken or shared at a local level. At this inspection, we found that the management team had improved the process and ensured that relevant medicine and equipment alerts were shared with staff in a timely manner. A box containing diagnostic equipment was given to all clinicians who treated patients at WUCC at the start of their shift. The box also contained copies of medicine and equipment alerts received, which made them easily accessible for staff to read. GPs and nurses spoken with demonstrated an awareness of safety alerts. In addition a regular newsletter had been issued with details of safety alerts, which was emailed out to staff.

Overview of safety systems and processes

- At the previous inspection, we found that the provider had comprehensive recruitment systems in place but

personnel files we reviewed demonstrated recruitment policies and procedures were not consistently adhered too. At this inspection, we saw that the provider safer recruitment policy had been updated in June 2017 and an audit carried out prior to our inspection to review recruitment files for staff working at WUCC. We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment for all staff. These included proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service. A total of 33 staff had been recruited since the last inspection. Staff recruited included sessional GPs, advanced nurse practitioners, emergency care practitioner, junior nurse practitioners, receptionists, physician associates and a team leader. The service shared its end-to-end recruitment process with us and up to date procedures were seen which demonstrated safe recruitment practices had been consistently followed.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety.

- We found that improvements had been made following the last inspection to ensure that there were enough staff on duty to meet expected demand, at various time of the week, which included weekends. Copies of working rotas over previous weeks, random weekends and for the month of October were seen to confirm this. WUCC used a computerised rota system (rota master) for all the different staffing groups to ensure that sufficient and the appropriate mix of staff were on duty. Discussions were held with the management team about the efficient use of staff particularly where we saw evidence of breaches in the length of time taken to see patients who had an appointment at WUCC. We saw that improvements had been made to ensure that sufficient home visiting capacity was available to manage the out of hours service. The management team had identified problems with the central despatch team located in Stafford. Information we looked at showed that on one occasion eight patients requiring a home visit had not been appropriately managed by the despatch team during a night shift. These patients were referred to the centre the following morning, which meant that there was delay in the patients receiving a home visit. We saw that the clinical director at WUCC had put plans in place to manage these patients and mitigate the level of risk. This was also recorded as a significant event and escalated as an issue within Vocare.
- The local CCG had shared information about children attending WUCC for planned appointments who had not received an assessment in a timely way. These children were all over one year old. Parents had also left the centre without their children being seen and had not informed a member of staff they were leaving. WUCC carried out an audit to review this and looked at children who attended the centre during August 2017. We looked at the records of four children who had arrived at WUCC during August 2017. We found three children had left the centre without being seen and one had initial observations carried out but left before they received a full clinical assessment. We also looked at random records for two separate days in October to review the length of time, children given an appointment at WUCC had to wait before they were seen by a clinician. We looked at 16 records for one of the days. These identified ten children with routine appointments. The shortest wait was 41 minutes after their appointment time and the longest wait was two hours forty six minutes. The remaining six patients had been allocated an urgent appointment. The shortest waiting time was 26 minutes after their appointment time and the longest wait was two hours twenty two minutes. For the second date in October, nine records showed seven children had been allocated a routine appointment. The shortest wait for these children was seven minutes after their appointment time and the longest wait was one hour fifty seven minutes. Two patients had been allocated urgent appointments. The earliest time seen was 14 minutes after their appointment time and the longest wait was one hour six minutes. We found that there was limited information to confirm that appropriate action had been taken to address the problems related to waiting times and children leaving the centre. The audit carried out in August had not been repeated to identify any trends, whether it was an ongoing problem or that any actions had been considered.
- We discussed the above with the clinical director who told us the management team were aware of the concerns but we did not see that a mitigation strategy hadbeen put in place. At the time of this inspection, the

management team developed interim guidance to support staff to address this and to mitigate risks. Following the inspection the provider sent us a detailed flow chart to demonstrate the process put in place to address and monitor this over the longer term. The document contained details of the timeline in which children who attended the centre would be assessed. This was broken down to cover children under the age of one year, children over the age of one and whether they had an appointment or not.

- The management team told us about the plans that had been introduced to address staffing shortages identified at our last inspection. Ongoing recruitment plans were in place and new staff recruited included sessional GPs, advanced nurse practitioners and physician associates. The roles of clinical staff had been extended so that qualified staff, which included for example the advanced nurse practitioners undertaking home visits, and other clinical staff had also been trained to verify expected death at the patient's home. WUCC was also in the process of implementing a standard operational procedure (SOP) agreement with the Royal Wolverhampton Trust (RWT) to mitigate the risks of long delays in waiting times for both adults and children. The SOP allowed WUCC to refer children and adults to the hospital emergency department at times when WUCC did not have the capacity to meet the needs of patients, which could be due to insufficient staffing levels. There remained occasions when the service could not demonstrate their ability to match their capacity. However, the proposed changes were planned to support the service to manage and mitigate risk at periods of peak demand, such as Saturday and Sunday mornings, and Bank Holidays.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

During our inspection in March 2017, we saw that:

- There was a lack of an effective system to ensure that NICE guidelines and updates were received and actioned in a timely manner.
- Systems and processes for the auditing of GP clinical assessments were not effective to ensure that appropriate actions were taken when concerns were identified.
- Not all staff were trained to appropriate levels in paediatrics (care of children).
- Competency checks were not carried out to ensure that staff qualified to care for young children had up to date skills and knowledge.

At the inspection in March 2017, we were told that staff had access to guidelines from National Institute for Health and Care Excellence (NICE) best practice guidelines and used this information to deliver care and treatment that met patients' needs.However, we found that there were no mechanisms in place to assure us that NICE guidelines and updates were received locally and actioned where appropriate in a timely manner. At this inspection, we found that systems had been reviewed and mechanisms put in place to address this.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We saw that best practice guidelines were shared with staff at staff meetings, email communication and through a monthly newsletter.
- The service monitored that these guidelines were followed.
- Clinical staff, which included healthcare assistants who undertook baseline observations on walk-in patients had information relating to normal values and vital signs, which enabled them to easily escalate concerns where appropriate.

At the inspection in March 2017 we found that medicines included in the WUCC formulary showed that prednisolone was used in children as opposed to dexamethasone (Prednisolone and dexamethasone are used to control the body's response to inflammation and treat conditions such allergic disorders, skin conditions and breathing disorders). We found at this inspection that this first line treatment had been changed and instructions made available to relevant clinicians to use dexamethasone as recommended in current national guidance.

Management, monitoring and improving outcomes for people

WUCC used information collected as part of the National Quality Requirements (NQRs) and other quality indicators to monitor the quality of its service. NQRs are set by the Department of Health to ensure that GP out of hours services operated safely, are clinically effective and responsive. This includes audits, whether face-to-face assessments happen within the required timescales, patient feedback and actions taken to improve quality. WUCC was contractually required to meet a range of national and local quality and performance indicators and provide monthly performance reports to the clinical commissioning group.

NQR Four states that providers must regularly audit a random sample of patient contacts focussed on the quality of triage, telephone consultations and face-to-face consultations for the out of hours service. Appropriate action should be taken on the results of the audits. Regular reports of these audits must be made available to the appropriate contracting commissioning body. At the last inspection we found that effective systems to measure the performance of WUCC for this requirement were not in place. At this inspection we saw that the clinical audit policy had been updated and new procedures introduced. This provided clear guidance for staff involved in the reviews on the criteria to be followed when auditing patient contacts undertaken by clinicians. Evidence available for September 2017 showed that a review of calls and notes for 11 GPs had been completed We looked at the outcome of audits which were detailed, demonstrated two way discussions and showed that appropriate action had been taken where audits identified issues related to the competence of clinicians.

Effective staffing

At the last inspection we found that there was an inconsistent approach towards the management of children and some nurse practitioners were not trained in the clinical assessment of children under the age of one year. At this inspection we saw that this had improved and further improvements were planned to ensure advanced

Are services effective?

(for example, treatment is effective)

nurse practitioners (ANPs) had the skills, knowledge and experience to deliver effective care and treatment to young patients (children). This was intended to prevent children waiting for long periods and also ensure a suitably qualified clinician was available to see children when the GP was carrying out home visits at night. All reception staff were aware of the nurses identified as triage nurses. Staff were aware of the advanced nurse practitioners who could carry out assessments of children under the age of one year

- WUCC had put arrangements in place to ensure children under the age of one year who arrived as walk in patients received a clinical assessment within 15 minutes of their arrival at the centre. This assessment was carried out by an advanced nurse practitioner (ANP). The management team planned that nurse practitioners would be appropriately trained and qualified to undertake assessments of children.
- At the time of this inspection the centre had one ANP who had received appropriate training in the care and treatment of children with minor illnesses and minor injury. We were not able to speak with this ANP at this inspection. We spoke with the ANP allocated to carry out the assessment of children under the age of one. This ANP was trained in the resuscitation of babies and young children and had completed safeguarding level 3 training. They had not however completed minor illnesses and minor injury training related to children.
- The current competency level of all ANPs who carried out an assessment of children was not in line with the draft paediatric minor illness - competency assessment framework developed by the provider. However, arrangements had been made for four urgent care practitioners to attend a three day course for the management of children with minor illness in November 2017. This would then be followed up with support to develop their competencies, followed by a competency assessment before seeing children on their own.
- There was not a standard assessment tool for all ANPs to use when undertaking triage assessments of children. Staff told us that their assessments and approach were based on their professional judgements. This could result in gaps in the assessment and inconsistencies in the questions asked.
- The arrangements for the formal appraisal and supervision of nurses were being reviewed. The management team had identified that these reviews had to be completed by an appropriate and suitably qualified clinician and were in the process of addressing this. The ANPs on shift were able to confirm that ongoing peer clinical support could be accessed through other clinicians. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Access to the service

During our inspection in March 2017, we saw that:

- There was an inconsistent approach to the management of children under the age of one year who attended the centre, which could potentially lead to young patients (children) waiting for long periods.
- There was a lack of systems for the safe triage of walk in patients, who were not given an appointment, with a reliance on clinical staff 'spotting' a higher priority patient from their electronic list or observation of the waiting area.

At our inspection in March 2017, we found that concerns received prior to the inspection verified that demand had exceeded staff capacity and had an impact on all services provided on varied dates over some weekend periods. This had led to breaches in service level agreed time limits, and patients being re-triaged by clinical staff. At this inspection, we found that although there remained some occasions when there were delays in seeing patients, systems had been reviewed to manage these and mitigate risks. We found that the capacity to undertake home visits had improved. Advanced nurse practitioners had received training to equip them to undertake home visits and an additional car had been made available which allowed additional visits to be completed.

At the last inspection, we found there was a lack of systems for the safe triage of walk in patients. These patients were not given an appointment and there was a reliance on clinical staff 'spotting' whether walk-in patients were a higher priority patient. At this inspection we found that the service had introduced arrangements for walk in patients to be assessed in timely manner. A triage shift was carried out daily to ensure walk in patients were seen within 15 minutes of arrival at the centre. The shift was provided between the hours of 10am and midnight and covered by a clinician. Arrangements were also introduced to ensure young children under the age of one year arriving as walk in patients received a clinical assessment within 15 minutes of their arrival at the centre.

Reception staff had received training to support them to manage and monitor patients waiting in the reception area. The training provided staff with basic knowledge for identifying visible signs of deterioration in a patients' health. Staff had access to an aide memoire, which also detailed the action they should take if a patient's wellbeing deteriorated. A clinician was also involved in monitoring patients' wellbeing in the waiting room. WUCC had updated its operational procedures for this and was awaiting confirmation to fully implement the procedures.

Patients were also provided with information and instructions titled 'New or Worsening Symptoms' on what they should do if there was any change in their condition. This included ensuring they informed the receptionist. We discussed a list of 'Patient Safety Questions' given to patients to complete and hand back to the receptionist when booking in. Patients were asked to read the questions and answer them as accurately as possible. The questions were worded in a way that suggested they were assessing another patient and did not appear appropriate. For example, some of the questions asked stated; "Is the patient conscious?", "Is the patient breathing?", "Does the patient look severely ill?", and "Are you experiencing any mental health symptoms?"

Are services well-led?

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

Our findings

Vision and strategy

During our inspection in March 2017, we found that effective governance arrangements were not in place. At this inspection we found that improvements had been made. We found there was a more cohesive approach to the management and operation of the centre. There was evidence of a whole staff approach and involvement in the improvement of the service which ensured that WUCC vision and values were embedded.

Governance arrangements

At the previous inspection we found that appropriate governance arrangements were not in place in all areas. At this inspection we found that governance arrangements were actively supported by a regional team.

Governance arrangements had been reviewed for identifying, recording and managing risks related to operational and clinical practice. For example;

- Appropriate systems for the auditing of GP clinical assessments had been introduced to ensure appropriate action was taken in a timely manner when concerns were identified.
- Recorded information demonstrated that the learning outcomes from significant events, complaints and incidents were shared with all staff was available.
- Communication with staff at a local level had improved. Records looked at showed that regular governance meetings and an early morning meeting was held with staff on duty to discuss events that may affect the operation of the centre such as staff shortage and what mitigating action was needed to address these.
- Arrangements for the safe triage of walk in patients who were not given an appointment had been reviewed. However, we found that children with an appointment were not assessed in timely manner. The impact of this was discussed with the management team. The management team responded at the time of the inspection and a mitigating strategy was put in place.

Effective systems were in place to demonstrate that alerts issued by the Medicines and Healthcare Regulatory Agency about medicines were acted on.

Effective systems to ensure NICE guidelines and updates were received and actioned in a timely manner had been implemented.

Recruitment procedures had been reviewed and safe recruitment practices introduced and consistently followed.

We found that a number of operational procedures had been in draft format for some time, this prevented the full implementation and embedding of new changes to support effective monitoring of the services provided.

Leadership and culture

At this inspection we found there was a clear leadership structure in place. The improvement in areas under the influence of the clinical director was particularly noted at this inspection. Staff told us they had the opportunity to raise any issues and felt confident in doing so. Effective arrangements to ensure staff were involved and up-to-date with any changes had been introduced. These included monthly staff team meetings both clinical and non-clinical, monthly newsletters, a shared intranet platform and emailed communication, a monthly newsletter, clinical bulletin reports. Copies of the minutes of meetings and newsletters for October 2017 were shared with us. These documents were detailed and included discussions related to significant events, safety alerts, complaints and the day-to-day operation of the practice.