Erdington GP Health and Wellbeing WIC

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?	Requires improvement
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 Erdington GP Health and Wellbeing Walk in Centre on 19 January 2017. Overall the service is rated as requires improvement.

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

- There were effective systems in place for recording, reporting and learning from significant events.
- We found in some areas there were effective systems to keep patients safe including safeguarding patients from abuse, safe prescribing and ensuring sufficient staff on duty. However, we also found areas of weakness for example, in relation to recruitment checks.
- Risks to patients were not always effectively managed and we found gaps in the management and monitoring of risks relating to the premises.
- Patients' care needs were assessed and delivered in a timely way according to need.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had appropriate skills, knowledge and experience to deliver effective care and treatment.
- There was a lack of systems in place to monitor the quality of services provided. Although consultations with nursing staff were audited there were no systems in place for GP performance. There was also little evidence of quality improvement activity for example through clinical audit.
- Patients were positive about the service received and said they were treated with dignity and respect and were satisfied with their involvement in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. There was evidence of learning from complaints which supported improvements to the quality of care.
- The service was accessible to all patients and helped provide an alternative to attendances at hospital.
- The provider had good facilities and was well equipped to treat patients and meet their needs.
- There was clear leadership in the day to day management of the service and staff felt supported by

Summary of findings

the Clinical Nurse Manager. Regular staff meetings were held to ensure important information was shared. However, there was a lack of clear senior medical support in the governance arrangements.
- The provider proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- The provider did not currently have a registered manager with CQC. Relevant applications had been started but not completed.

The areas where the provider must make improvement are:

- Ensure effective systems are place to assess, monitor and mitigate risks to the health, safety and welfare of service users and others who may be a risk. This would include the monitoring of the cleaning of the premises, the follow up of actions relating to fire and legionella risk assessments, for ensuring COSHH safety information is accessible when needed and for monitoring staff training and recruitment information.
- Ensure effective systems are in place to assess, monitor and improve the quality and safety of the services.

The areas where the provider should make improvement are:

- Review business continuity plan to identify the benefits of adding relevant staff contact information.
- Maintain accurate records of prescription use.
- Ensure locum pack is kept up to date.
- Review arrangements for senior medical support for the service including contingency arrangements.

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. as there are areas where improvements must be made.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective system in place for recording, reporting and learning from significant events
- Lessons were shared to make sure action was taken to improve safety in the service.
- When things went wrong patients were informed in keeping with the Duty of Candour.They were given an explanation based on facts, an apology if appropriate.
- There were clearly defined and embedded system and processes in place to keep patients safeguarded from abuse.
- There were processes in place to ensure sufficient staff were on duty and managing periods of high demand on the service.
- Processes were in place to support safe prescribing however, there was no evidence of any pharmacy or medical support in this area and little evidence of prescribing audits undertaken.
- Recruitment checks did not always demonstrate that effective recruitment processes were consistently applied. For example, for sessional GPs we saw DBS checks that were not current at the time of recruitment and no references present.
- The premises appeared clean and tidy and well maintained. However, we found weaknesses in the systems for monitoring risks relating to the safety of the premises. For example, no cleaning schedules were made available or evidence that actions from risk assessments had been followed up.

Are services effective?

Requires improvement

The service is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- The practice produced quarterly performance reports for the CCG, this showed satisfactory performance against the key performance indicators set.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Consultations undertaken by the Advanced Nurse Practitioners and Healthcare Support Workers were routinely monitored. However, there was no similar system in place for the GPs to identify how they were performing or learning needs.

Summary of findings

- There was little evidence of quality improvement activity such as clinical audit.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. However, there was a lack of systems in place to ensure staff remained up to date with core training.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from patients through CQC comment cards and collected by the provider was very positive.
- Patients said they were treated with dignity and respect by friendly and caring staff.
- Patients were happy with the service they received and their involvement in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient confidentiality.
- Patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service. Notices displayed gave patient information about expected waiting times and that some patients may need to be prioritised and seen before them.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- The provider reviewed the needs of its local population and engaged with its commissioners about the service provided. Patient feedback demonstrated patients were happy with the service.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- The provider had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

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

Summary of findings

- The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about their responsibilities and supported this vision,
- There was clear leadership in the day to day management of the service and staff felt supported by the Clinical Nurse Manager. Regular staff meetings were held to ensure important information was shared.
- Policies and procedures were in place to govern activity but were not all up to date.
- There was an overarching governance framework to support the delivery of the strategy and good quality care. However, there was a lack of senior medical input to support in the performance management of medical staff.
- Although there were arrangements for identifying and managing risks these were not always effectively monitored to ensure action had been taken. For example in relation to premises and recruitment checks.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The provider had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The provider proactively sought feedback from staff and patients, which it acted on.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the service they received from the walk in centre. Patient feedback was obtained by the provider on an ongoing basis and was included in their contract monitoring reports. Data from the provider for the period of July and September 2016 based on 632 responses (approximately 8.6% of consultations) showed:

- 98% rated the receptionist as good or excellent
- 98% rated the triage/health care assistant as good or excellent
- 97% rated the doctor or Advanced Nurse Practitioner as good or excellent
- 92% rated the waiting time as good or excellent
- 97% rated the overall experience ad good or excellent

The practice had an active patient user group that it regularly engaged with. We met with a representative from the group who was very complimentary of the service.

Comments seen on the NHS Choices website which invites patients to provide feedback on the services they used showed patients rated the provider four and half out of five stars based on 33 reviews. Ten of the reviews were made within the last 12 months.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 24 comment cards which were all positive about the standard of care received. Patients rated the service highly, found staff helpful caring and professional. The only negative comments (of which there were six in total) related to long waiting times.

Erdington GP Health and Wellbeing WIC

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 nurse specialist adviser.

Background to Erdington GP Health and Wellbeing WIC

Erdington GP Health and Wellbeing Walk in Centre opened in 2010 originally as a GP practice and walk in centre to meet the needs of the local population and a lower proportion of GPs in the area. However, due to lack of demand the contract for the GP practice was terminated after two years but the walk in centre remained.

The provider organisation is Badger Midlands Medical Ltd. Badger Midlands Medical Ltd is a joint venture between two organisations Badger (an out of hours provider) and Midlands Medical Partnership (a partnership of 11 GP practices in the local area). Badger take responsibility for the finance and human resource element of the service and Midlands Medical Partnership the day to day running of the service.

The provider holds a contract with Birmingham Cross City CCG. Any person entitled to NHS care in the UK can access the service. No appointments are required. Patients access the service in person and wait to be seen.

The walk in centre is open 8am to 8pm daily, 365 days a year (including all bank holidays). Since 1 April 2016 the service had received on average approximately 7500 visits per quarter.

Between Monday and Friday staffing typically consists of a GP, an Advanced Nurse Practitioner (ANP) and two Health Care Support Workers (HCSW). During times of high demand for example during winter pressures this is increased to two ANPs. At weekends, typical staffing consists of one GP, three ANPs and two HCSWs. The majority of staff including GPs work on a sessional basis.

The centre was managed on a day to day basis by the Clinical Nurse Manager whose time is split between management and clinical duties. They are supported by a senior medical lead and Operational Manager who are not based at the service but visit weekly to meet with the Clinical Nurse Manager.

The service did not currently have a registered manager with CQC. A new registered manager had been identified and relevant applications had been started but not completed.

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.

The service was previously inspected as a pilot site for the new primary medical services inspection methodology on the 26 February 2014 but was not rated. As this inspection we followed up compliance actions that were identified as part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 that were in place at the time. These highlighted concerns in relation to staff recruitment and support.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 19 January 2017. During our visit we:

- Spoke with a range of clinical and non-clinical staff (including the Clinical Nurse Manager, GPs, ANPs, HCSW and administrative staff).
- We spoke with a representative of the patient user group.
- Inspected the premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- We reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed documentation made available to us for the running of the practice.

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

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

Please note that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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

- Systems for reporting 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 and an apology.
- Staff told us they would inform the Clinical Nurse Manager of any incidents and when an incident occurred staff on duty would take a short time out as a team to discuss and debrief.
- Significant events and complaints were discussed and learning shared at the monthly staff meetings where they were a standing item on the agenda. These meetings were open to all staff including those who worked on a sessional basis and minutes of those meetings shared with those who could not attend.
- Significant events and incidents were shared with the CCG as part of their quarterly performance reports.

Safety alerts such as those from the Medicines and Healthcare Products Regulatory Agency (MHRA) were received by the Clinical Nurse Manager who circulated these to all clinicians via email. Hard copies of the alerts were also placed in each clinical room. We saw evidence of safety alerts that had been acted on.

Overview of safety systems and processes

The provider had systems, processes and services in place to keep patients safe and safeguarded from abuse, however, we identified some areas for improvement:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and information was displayed which informed them who to contact for further guidance if they had concerns about a patient's welfare. Safeguarding information was also displayed in the waiting area for patients to access. There was a lead member of staff for safeguarding and staff we spoke with were aware of who the lead was. Staff demonstrated they understood their responsibilities and were able to share examples with us of concerns they had raised and referrals made in response to concerns. Safeguarding referrals were discussed at the staff meetings. We saw that the GPs and ANPs had been trained to child safeguarding level 3.
- The Healthcare Support Workers acted as chaperones. We saw evidence that they had received relevant training. We spoke with two Healthcare Support Workers on duty who demonstrated an understanding of the role. From the staff records seen we saw a Disclosure and Barring Service (DBS) check had been undertaken for these staff. (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).
- The premises used by the provider appeared visibly clean and tidy. Staff had access to appropriate hand washing facilities, personal protective and cleaning equipment to maintain appropriate standards of cleanliness and hygiene. There was an infection control lead who had received infection control training within the last 12 months. Infection control was part of staff induction and we saw evidence of training sessions with health care support workers and administration staff. Cleaning logs were maintained for clinical equipment. An infection control audit had been undertaken during August 2016 and an action plan in place was monitored to ensure actions had been completed. The service reported compliance against the infection prevention and control standards in the quarterly CCG performance reports. We saw appropriate arrangements for the safe storage cleaning products and clinical waste. Information relating to action required in the event of sharps injury was displayed.
- Cleaning was managed through NHS Property Services. The contract for cleaning had changed in May 2016. Staff were unable to locate any cleaning schedules or other cleaning records for example frequency of cleaning of carpets. Immunisation records were maintained for clinical staff and we saw examples of these in three staff files. However, no risk assessments had been undertaken to assess and mitigate potential risks to non-clinical staff involved in cleaning bodily fluid spills.
- We reviewed five personnel files. This included two sessional GPs, two ANPs and a healthcare support worker. In most cases appropriate recruitment checks

had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service. However we did notice that for one GP there was no references, the DBS check was not current at the time of employment and there was no evidence that they were on the NHS England performers list. At our previous inspection in February 2014 we also identified issues with recruitment checks which related mainly to evidence being unavailable at the time as we were advised it was held with Badger (one of the parent companies).

Medicines Management

- The provider maintained a limited stock of medicines for use in an emergency. There were certain medicines that the walk in centre would not prescribe and these were displayed by reception. The practice maintained an alerts folder for patients known to ask for certain medicines.
- Patients were requested to complete a registration form which included information about current medicines. Prescriptions for long term medicines would be kept to a minimum until the patient could see their usual GP.
- All nursing staff were prescribers. The Advanced Nurse Practitioners prescribing was routinely audited and feedback was given by the Clinical Nurse Manager. Where healthcare support workers administered medicines there were clear processes in place for Patient Specific Directions (PSDs). (A PSD is a written instruction signed by a prescriber (for example a doctor for medicines to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.)
- Blank prescription forms and pads were securely stored but there were no systems in place for monitoring their use. We discussed this with the Clinical Nurse Manager who told us that they would address this and produced a form for recording prescriptions allocated to each printer in the future.

Monitoring risks to patients

Risks to patients were assessed but were not always well managed.

- The premises appeared well maintained. Staff told us that the premises were let to NHS properties who sublet to the CCG for the provision of the walk in centre. Maintenance and facilities were managed by NHS Properties. This included cleaning, waste management, fire, legionella and security arrangements. Any maintenance issues were logged by staff at the walk in centre and passed on to NHS properties who regularly met with the provider.
- The provider had up to date fire risk assessments, there was a fire evacuation plan and records showed that the fire alarm was regularly tested and that there had been a fire drill within the last six months. We saw evidence that the fire equipment was last serviced in July 2016. However, we found that the action plan from the fire risk assessment had not been updated and the provider could not assure itself as to what action had been taken. We also saw from the monthly checks on emergency lighting and exit there had been some areas that had failed the checks but no evidence of action taken. For example, emergency lighting in the disabled toilet showed that it had continually failed the monthly checks since July 2016.
- The provider had a legionella risk assessment which was also managed by NHS Properties dated July 2014. There was an action plan in place which included urgent actions but there was no record or evidence that this had been completed. (Legionella is a term for a bacterium which can contaminate water systems in buildings.)
- Although we saw COSHH risk assessment in place, the provider was unable to locate safety information sheets for products used which would identify what action to take in an emergency.
- Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was regularly calibrated to ensure it was working properly. These checks had been undertaken in the last 12 months. Staff told us that there was sufficient equipment and stock to do their job and at peak times would ensure extra stock available for example, dressings for wound care over the Christmas period.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The majority of staff who worked at the walk in centre were employed on a sessional basis. Staff told us that many of the sessional staff also worked for Badger (one of the parent

companies). Staff rotas were planned a month in advance to ensure there was sufficient staff on duty. The Clinical Nurse Manager told us that they did not usually experience difficulties filling shifts. Staffing at any one time, Monday to Friday, typically consisted of a GP, an Advanced Nurse Practitioner (ANP) and two Health Care Support Workers (HCSW). During times of high demand for example winter pressures the provider increase this to two ANPs. At weekends, typical staffing was one GP, three ANPs and two HCSWs. The centre was managed on a day to day basis by the Clinical Nurse Manager whose time was split between management and clinical duties.

- The provider also had escalation procedures in place at times of unexpected high demand. This transferred the service from a walk in centre to an urgent care centre. Patients were still triaged but only those with urgent needs as assessed by a clinician were treated. Patients with less urgent needs who were not treated were signposted back to their GP or other alternative services available.

Arrangements to deal with emergencies and major incidents

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

- There was an effective system to alert staff to any emergency. Staff could alert other members of staff via their computers or personal alarms that they carried with them.
- In most cases training records seen showed staff were up to date with annual basic life support training.
- The provider had emergency equipment including a defibrillator and oxygen and emergency medicines available if needed.
- Emergency medicines were easily accessible and all staff we spoke with knew of their location. All the medicines we checked were in date and stored securely.
- There was a comprehensive business continuity plan for the whole building as well as one specific to the provider. These contained relevant contact information for various services in an emergency. However we did not consider staff contact details were sufficiently readily available should they need notifying in an emergency.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Staff we spoke with told us that they accessed best practice guidelines such as NICE and British National Formulary (BNF) guidelines online.
- Clinical staff we spoke with were aware of recent updates in NICE guidance such as the sepsis update and feverish child. They were able to access update sessions run by Badger.
- The healthcare support workers who undertook baseline observations when patients arrived at the service had information relating to normal values and vital signs, which enabled them to easily escalate concerns to clinicians.
- We saw that clinical staff had access to the CCG antimicrobial guidelines although, not all were aware of the most up to date version.

Management, monitoring and improving outcomes for people

The walk in centre held a contract with Birmingham Cross City CCG. Performance reports are submitted to the CCG on a quarterly basis. These reports covered areas such as waiting times, incidents, complaints and patient experience. Reported performance was consistent over that last 12 months. The most recent performance information available from the provider related to quarter 2 (July to September 2016) and quarter 3 (October to December 2016). This showed:

- 90% of patients were seen within 45 minutes of arrival during quarter 3 (October to December 2016). During the last 12 months the percentage of patients seen within 45 minutes of arrival ranged from 89% to 97%.
- Average length of appointment with clinician was just over 13 minutes during quarter 3 (October to December 2016). During the last 12 months the average length of appointment ranged from 12 minutes to 15 minutes.
- 97% rated the service as good or excellent and 0.2% as poor during quarter 2 (July to September 2016). During the last 12 months the percentage of patients who rated the service as good or excellent ranged from 88% to 97%.

The Clinical Nurse Manager undertook six monthly audits of patient consultations with the Advanced Nurse Practitioners and Healthcare Support Workers. Staff received individual feedback on their performance to support learning and improvement. However, there were no systems in place to monitor GP performance currently in place.

There was little evidence of any systems in place to support quality improvement. We saw no full cycle audits. We were told about an audit of Accident and Emergency attendances but this did not have a purpose or evidence of follow up.

The provider did not have any direct pharmacy support and there was little evidence of any clinical audits relating to medicines and prescribing to support improvement.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The provider had an induction programme for all newly appointed staff and we saw examples of these for a health care assistant. We saw that staff were required to meet specific competencies for their role which were signed off on completion. We spoke with a member of staff who confirmed they had received an induction at the service which included an introduction to the IT systems, shadowing more experienced staff and training such as basic life support and safeguarding.
- There was a locum induction pack which was comprehensive but needed updating as it included the names of two managers who had now left.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff. For example, we saw evidence of appropriate training for the Advanced Nurse Practitioners (ANP). The Advanced Nurse Practitioners (ANP) told us that they would see all patients but would refer to the GP on duty if there was anything outside their competencies.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff we spoke with told us that they felt the provider organisation was supportive of their training needs. Staff could access continuing professional development updates through Badger (parent organisation).
- At our previous inspection in February 2014 we identified gaps in the appraisal processes.
- At this inspection the learning needs of staff were identified through a system of appraisals. We saw evidence of appraisals for nursing and administrative staff. Evidence was also seen that the GPs on duty during our inspection had undergone revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.
- It was difficult to verify that all staff (including those working on a sessional or locum basis) were up to date with core training without going through individual staff files. We reviewed a sample of five staff files and saw gaps in fire and Mental Capacity Act training. However, we saw that staff had access to training which included: safeguarding, basic life support, information governance and infection control.

Coordinating patient care and information sharing

The provider used the Adastra system for recording patient consultations. This is a system used by out of hours providers. The provider did not have access to the patient's GP or hospital records when providing care or treatment but could contact the patient's own GP or hospital for essential information during core hours if this was needed to provide treatment. Patients were requested to complete a registration form on attending the service. This enabled the clinicians to obtain some information about the patient prior to seeing or treating to assist with any clinical decisions. This included information such as known allergies, current medication and details of symptoms leading to attendance at the walk in centre.

A resource folder held in reception enabled staff to signpost patients to various services available locally. For example, counselling services and alcohol and drugs support. It also held referral in formation for hospitals and mental health services.

Details of consultation were forwarded to the patient's usual GP to support the continuity of care. This was carried out as an automated process.

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 and when providing care and treatment for children and young people.
- We saw evidence from training records that some staff had received mental capacity act training.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Staff were mindful of maintaining patient confidentiality, we saw the receptionist lowering their voice to minimise the risk of being overheard during conversations with patients.
- A notice displayed in reception advised patients that they could offer a private area if they wished to discuss their needs in private.
- Notices displayed gave patient information about expected waiting times and explained that some patients may need to be prioritised as urgent and seen before them. Details of staff on duty were displayed so that patients who they were seeing.
- Mobile screens were available if needed in the waiting area to provide privacy.

All 24 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the service offered was excellent. That staff were helpful, caring and treated them with dignity and respect.

We spoke with a representative of the patient user group who was also very complimentary of the service. They told us that feedback from patients from their in-house patient survey and through NHS choices was always positive.

The provider's in-house patient survey was carried out on an ongoing basis. It asked patients to rate the individual staff they encountered and comment on their overall experience The latest data available showed patient satisfaction scores between July and September 2016 (quarter two). During this period the service received 632 completed surveys. Results showed:

- 98% rated the receptionist as good or excellent
- 98% rated the triage/health care assistant as good or excellent
- 97% rated the doctor or Advanced Nurse Practitioner as good or excellent
- 92% rated the waiting time as good or excellent
- 97% rated the overall experience ad good or excellent

Care planning and involvement in decisions about care and treatment

Feedback received from patients through the completed CQC comment cards indicated that they were happy with the service and their involvement in decision making about the care and treatment they received. Patients told us they felt listened to and supported by staff. The provider's own patient survey did not include any questions about patient involvement and decision making.

The provider held information sheets to advise patients so that they could be involved in their care and treatment for example, information about head injuries, antibiotic use and about alternative care available.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing reception staff how to access this telephone service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider reviewed the needs of its local population and regularly engaged with its commissioners. Patients were very happy with the service provided and several commented that it was easier to access than their own GP.

The service provided was accessible and open to patients from within and outside the local CCG area. Practice staff told us that patients who were not registered with a GP would still be seen and that they saw patients from local temporary accommodation who were unregistered with a GP.The premises were suitable for patients with mobility difficulties and for babies and young children. There was lift access to the walk in centre and sufficient space for wheelchairs and pushchairs to manoeuvre. An evacuation chair was available in case the lift was not in use such as in the event of fire. A low reception desk made it easy for patients who used a wheelchair to speak with reception staff. Disabled toilet facilities and a dedicated room for breast feeding and nappy changing was also available. We saw reception staff provide paper and pencils for children to draw to keep them occupied while waiting.

The service was located on a busy high street accessible by public transport. The provider did not have its own patient parking facilities but there was a public car park situated to the rear of the building.

There were systems in place to ensure those with the most urgent need were seen as priority. Children under five were automatically given priority and the triage system helped identify any patients who may be in urgent need.

Access to the service

The walk in centre was open 8am to 8pm daily, 365 days a year (including all bank holidays). Patients did not need appointments to access the service. Patients attended in person and were seen according to priority. This was usually based on initial triage assessments. Some patients were referred in from GPs, ambulance service and BADGER (out of hours provider).

Waiting times were monitored on an ongoing basis as part of the contract monitoring arrangements with the CCG.

During the last quarter (October to December 2016) the average waiting time from arrival at the walk in centre was 17 minutes with 90% of patients being seen with the 45 minute target.

Feedback received from patients from the CQC comment cards was very positive, there were a small proportion of patients who felt the waiting times were long.

At times of high service demand the service was escalated to an urgent care service. Patients were still triaged and a decision was made by the clinician to assess and treat those with urgent needs. Those not deemed as urgent would be redirected as appropriate to other services.

The walk in centre helped provide alternatives to patients who might otherwise attend hospital for care and treatment.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- The Clinical Nurse Manager was the designated responsible person who co-ordinated the handling complaints received. They were supported by one of the GPs who regularly worked for the provider.
- We saw that information was available to help patients understand the complaints system. A complaints leaflet was available at reception for patients to take away. This included details about the expected timescales for responding to the complaint and what to do if the patient is unhappy with the response received from the provider.

Between January and September 2016 the provider had received five complaints. These were dealt with in a timely way. Lessons were learnt from individual concerns and complaints were routinely discussed at the staff meetings which were open to all staff including those who worked on a sessional basis. Complaints were shared with the CCG as part of contract monitoring.

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 provider had a clear vision to deliver high quality care and promote good outcomes for patients. During our inspection staff demonstrated values that were caring and helpful with a desire to provide a good service. Feedback from patients supported this.

During the presentation senior managers spoke about the future of the service and the lack of long term clarity due to national changes to the way in which urgent care would be delivered.

Governance arrangements

The provider had an overarching governance framework that supported the delivery of the strategy and good quality care. However, we identified some weaknesses in the arrangements.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff on their computers. However, some of the policies and procedures were in need of reviewing and updating to ensure staff were using the most current information.
- The provider had some understanding of their performance through the contract monitoring arrangements with the CCG. There were effective systems for monitoring the performance of nursing staff. However there were no systems in place for auditing or monitoring the quality of consultations and performance by the GPs who worked on a sessional basis and there was little evidence of quality improvement activity such as clinical audit.
- The Clinical Nurse Manager who was responsible for the day to day running of the service worked part time (30 hours each week) and their time was split between clinical and managerial duties. They were supported by the Midlands Medical Partnership Operational Manager and the registered manager who visited the centre on a weekly basis when available.
- Although there were arrangements for identifying and managing risks these were not always effectively monitored to ensure action had been taken. For example, in relation to the premises, cleaning and staff recruitment checks and training and monitoring of prescription use.

Leadership and culture

The provider was aware of and had systems in place 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). The provider encouraged a culture of openness and honesty and had systems in place to ensure that when things went wrong with care and treatment affected people were informed of the facts and given an apology where appropriate, in compliance with the NHS England guidance on handling complaints.

- On the day of the inspection we found the service ran effectively. The Clinical Services Manager was highly regarded by all staff who were very complimentary about their leadership and felt well supported by them. The sessional GPs we spoke with told us they liked working at this service because they felt it was safe and well orgainsed.
- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included regular monthly staff meetings for all staff including those working on a sessional basis. This enabled important information to be shared including incidents, complaints and safeguarding concerns. Minutes of meetings were circulated to those who could not attend.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported.
- However we did not see evidence of sufficient senior medical support for the Clinical Nurse Manager in taking forward issues relating to the GPs. For example, complaints and concerns raised.

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

The provider encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Requires improvement

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

- The provider had gathered feedback from patients through ongoing patient surveys and complaints received. They also had an active patient user group of approximately six regular members that met with the service on a quarterly basis. The patient user group meetings were advertised in the waiting area. We spoke to a representative of the patient user group who told us that the service was receptive to feedback from patients and told us about some of the changes made including replaced seating, availability of hand gels for patients and other visitors to the service and colouring sheets to keep children entertained. The patient user group had also been involved in designing the patient survey. Patient feedback was a regular agenda item at staff meetings.
- The provider had gathered feedback from staff through staff meetings in which they had opportunities to contribute. A shift report completed by the receptionist at the end of each session enabled any issues arising during a shift to be escalated to managers for action if needed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have affective systems to assess monitor and improve the quality and safety of the services provided or to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk in the carrying on of the regulated activity.** • The provider did not have cleaning schedules to demonstrate the frequency and completion of cleaning tasks. • The provider did not assure itself that actions identified in fire and legionella risk assessments had been followed up and completed. • The provider did not have accessible COSHH safety information available for staff at the time of inspection. • The provider had not carried out risk assessments for all staff who may come into contact with bodily fluids. • The provider did not have systems for monitoring the performance of GPs. • The provider did not have effective systems to monitor the completeness of recruitment checks and staff adherence to core training. • The provider did not have effective systems for quality improvement activity for example through clinical audit.