Bracknell Urgent Care Centre

Quality Report

Brants Bridge Clinic
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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?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 7 October 2015. Overall the service is rated as requires improvement.

We undertook a focussed inspection on 17 and 24 August 2015 in response to concerns we had about the service. We imposed urgent conditions on the service as a result of the findings and issued a warning notice and a requirement notice. The inspection in October was a comprehensive inspection and we followed up on the concerns we identified in August. As a result of the findings of the inspection in October we were able to remove the urgent conditions as improvements had been made. However, we still found concerns specifically related to the effectiveness, safety and governance of the service. This has led to an overall rating of requires improvement.

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

- Incidents and accidents were being reported, investigated and reviewed. The outcomes were displayed for staff but no formal means of feedback was in place to ensure learning from such events.
- Some information about safety was recorded, monitored, appropriately reviewed and addressed.
- There was not always appropriate clinical cover for patients onsite after 8pm and those transferred to other services after 8pm
- Governance arrangements did not involve most staff at the centre who provided services in the way of meetings or other communication.
- The service was monitored by the local clinical commissioning group (CCG) and there were specific indicators the service worked to achieve. Since February 2015 the service had only met the waiting time target for adults in one month and had missed the 80% target for children in six consecutive months. The data we reviewed showed the targets for clinical assessment of patients over the six month period had been consistently missed. These had improved in September 2015 compared with previous months, but not all were met.
- No clinical audit was undertaken to identify improvements and learning related to clinical care

Summary of findings

- There had been a significant improvement to staffing levels since August, meaning greater patient safety, capacity to see patients and support for nursing staff.
- There were procedures for following up on patient referrals such as x-ray results.
- Communication with GP practices was taking place appropriately. Records of assessment and treatment were passed onto a patients' GP quickly.
- The service had a number of policies and procedures to govern activity, but locum staff did not have access to many of these and some were generic and not related directly to the centre.
- Staff were caring and considerate to patients' needs.
- Most of the feedback from patients we spoke with was positive.
- The service had sought feedback from patients. However, it was not liaising effectively with local Healthwatch.

The areas where the provider must make improvements are:

- Ensure all staff are aware of the outcomes and learning from significant events, incidents and complaints
- Ensure locum GPs and agency nurses have access to the provider's computer system where supporting information required to undertake their role is stored
- Review the monitoring of patients in the waiting area to ensure their safety and wellbeing
- Review the support and guidance available to staff, particularly locums, in regards to patient pathways.
- Review the need for a comprehensive programme of clinical audit as part of quality improvement.
- Provide staff with greater feedback and support through improved supervision and communication including meetings.
- Update the whistleblowing policy to ensure it contains information on the rights of whistleblowers and how they should escalate concerns externally

In addition the provider should:

- Review policies to ensure they reflect services provided and are relevant for staff
- Review the cover after 8pm to ensure there is a clear pathway for patients attending after 8pm to access the out of hours service.
- Make sure staff know there is a phone translation service available.
- Improve engagement with local Healthwatch to ensure that the views of the local community are considered and responded to in regard the provision of services.

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 centre is rated as requires improvement for providing safe services and improvements must be made. Lessons learned were not always fed back to staff following significant events. There was a lack of a system to monitor in the waiting area to enable staff to respond if a patient needed medical attention. On occasion staff were required to work after 8.30pm when their shifts ended and there was a risk they were not suitably supported at these times. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Staff were checked that they were safe to work with patients. Staffing during normal hours had improved since August to ensure GPs were available.

Are services effective?

Requires improvement

The centre is rated as requires improvement for providing effective services and improvements must be made. Locum GPs were providing clinical cover for most shifts along with employed and agency nurses. Locum GPs and agency nurses had limited access to One Medicare Ltd policies and internal systems where they may need to access supporting information. This included access to patient pathways for minor illnesses or injuries. There was minimal quality monitoring, such as clinical audit, but contract monitoring did take place. to identify improvements to care and treatment. Staff were aware of latest national guidance and best practice. Diversion of patients to other services had reduced significantly and there was evidence patients were assessed to ensure they were safe to be diverted to other services. Daily tasks were being assigned to staff such as reviewing x-ray results. There were appropriate procedures for obtaining consent.

Are services caring?

Good

The centre is rated as good for providing caring services. Patient feedback we received showed that patients regarded the service as caring and efficient. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The centre is rated as good for providing responsive services. Patients told us they usually found it easy to see someone at the centre. There had been a significant increase in staffing since August

Summary of findings

2015 and this had improved access and waiting times for patients. The service worked with some local community groups. The service had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Inadequate

The centre is rated as inadequate for being well-led. It had a vision and a strategy but not all staff were involved in reviewing its delivery and effectiveness. There was limited involvement in governance from staff who worked at the centre. Policies were not embedded to ensure staff used them and we saw evidence that policies were not always specific to the needs of the centre and its patients. Risks were not always identified, assessed and managed. The provider had not worked effectively with local Healthwatch. The culture in the centre was not conducive to open communication among staff and from leaders to staff. Leaders were not identifying problems reported to us by staff in order to ensure that where improvements to the service were identified, they were acted on. There was a leadership structure and delegated responsibilities. A new lead nurse provided support for nurses. The business manager had been proactive in identifying and communicating the resources needed to both the provider and commissioners to ensure improvements were implemented. The service proactively sought feedback from patients and had a small patient participation group. Staff received appraisals.

Summary of findings

What people who use the service say

All but one of 34 patient CQC comment cards we received were positive about the service experienced. All 14 patients we spoke with said they felt the service offered an efficient service and staff were helpful, caring and treated them with dignity and respect. Reception staff were specifically complimented for their efficiency and politeness. We saw that interactions between staff and patients were compassionate and respectful.

The centre achieved a 75% satisfaction rate in the friends and family test in September 2015.

Patients we spoke with told us that health issues were discussed with them and they 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients we spoke with were very complimentary about accessing the service. Comment cards also indicated that patients were pleased with the access at the service. Of the 14 patients we spoke with nearly all were happy with the time they waited for triage and eight out of nine patients we saw after triage were happy with their experience and waiting times. The majority of patients we spoke with were accessing the service during a period of low demand.

Bracknell Forest Healthwatch had collected feedback from local people regarding the urgent care centre over five months prior to our visit in October 2015. There was a mix of feedback regarding access, care received and facilities. There was a mix of positive and negative feedback from patients who had tried accessing the service. We also reviewed the information and feedback from patients on the NHS Choices website. We found positive and negative comments about the service.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff are aware of the outcomes and learning from significant events, incidents and complaints
- Ensure locum GPs and agency nurses have access to the provider's computer system where supporting information required to undertake their role is stored
- Review the monitoring of patients in the waiting area to ensure their safety and wellbeing
- Review the support and guidance available to staff, particularly locums, in regards to patient pathways.
- Review the need for a comprehensive programme of clinical audit as part of quality improvement.
- Provide staff with greater feedback and support through improved supervision and communication including meetings.
- Update the whistleblowing policy to ensure it contains information on the rights of whistleblowers and how they should escalate concerns externally.

Action the service SHOULD take to improve

- Review policies to ensure they reflect services provided and are relevant for staff
- Review the cover after 8pmto ensure there is a clear pathway for patients attending after 8pm to access the out of hours service.
- Make sure staff know there is a phone translation service available.
- Improve engagement with local Healthwatch to ensure that the views of the local community are considered and responded to in regard the provision of services.

Bracknell Urgent Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector **and accompanied by a second inspector,** a CQC GP regional adviser, a CQC national nurse adviser, a GP practice manager adviser and an expert by experience.

Background to Bracknell Urgent Care Centre

Bracknell Urgent Care Centre opened in April 2014 and provides a walk in see and treat service for the population of Bracknell and surrounding areas in both East and West Berkshire. The service is also available for patients who work or are passing through the Bracknell area and are registered with a GP service elsewhere. It is commissioned by the Bracknell and Ascot Clinical Commissioning Group (CCG).

The service is one of eleven GP practices and urgent care centres managed and operated by One Medicare Ltd. One Medicare Ltd is based in Yorkshire and Bracknell Urgent Care Centre is one of two centres operated by the organisation in the South of England. The provider's head office had strategic systems for governance which were cascaded to the individual centres they provided care from.

The service is commissioned to offer assessment, care and treatment for both minor illnesses and minor injuries. At the time of inspection all GPs working at the service were locums. There were a mixture of employed and agency nurses working at the centre. This equated to 5.8 whole time equivalent nurses. There was also a small team of reception staff. The service is open from 8am to 8pm every day of the year. Patients may call the service in advance of attendance but dedicated appointment times are not offered.

The service shares premises with other services including NHS Trust clinics, an x-ray department and the local out of hours service. When the service is closed patients can access the local Out of Hours service by calling NHS 111.

The service operates from:

Brants Bridge ClinicLondon RoadBracknellRG12 9GB

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. This inspection was planned to check whether the provider was 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.

We had previously undertaken a focussed inspection in August 2015 and this inspection followed up on concerns we identified. We undertook a focussed inspection on 17 and 24 August 2015 in response to concerns we had about the service. We imposed urgent conditions on the registration of the provider as a result of the findings and a requirement notice. At the inspection in October we followed up on the concerns we identified in August as well as looking at all aspects of the service we would usually inspect during a comprehensive inspection.

Detailed findings

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

How we carried out this inspection

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?

Before visiting, we requested and reviewed a range of information about the service and asked other organisations to share what they knew. We carried out an announced visit on 7 October 2015. During our visit we spoke with a range of staff including agency and locum staff, receptionists and members of the leadership team. We observed how people were being cared for and talked with patients. We reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The service used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as learning from complaints received from patients.

National patient safety alerts and medication alerts were disseminated among staff and action taken to ensure patient safety. All alerts were received by the medical director and the operational manager. They were disseminated to relevant staff via email or at 8am meetings at the centre called "huddles". These were the five minute briefing meetings at the start of each day for staff to share important information. Staff we spoke with told us that the meetings were useful but they did not always have the opportunity to discuss significant issues or concerns.

Learning and improvement from safety incidents

At our last inspection in August 2015 we found that staff we spoke with told us they had not submitted reports of potential significant events and incidents because they were fearful that their concerns would not be investigated and responded to. We heard that staff had not raised a significant event report when a GP did not report for duty on 28 July. Significant events were used as an organisation learning tool but not always communicated to front line staff. Staff were often not involved in the investigations and decisions about learning from such events.

In October 2015, we reviewed the records of significant events that had occurred during September and October 2015 we found that the provider had amended the system in place for reporting, recording and monitoring significant events, incidents and accidents. Reporting of events had improved. For example, we noted that when clinical staff had been late or absent this had been recorded. There was an accident book in place for staff to use. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. However, we identified that the learning and sharing of information from these events was limited. The minutes of the meetings we reviewed showed that significant events were discussed at clinical governance meetings. We noted that that these meetings did not include members of the clinical team based at the centre.

At the time of inspection there was no clinical lead at the centre but the new lead was due to start working in mid-October and part of their role would be attending clinical governance meetings.

Members of the leadership team at the centre told us that the regular morning briefing meetings were used to disseminate information, regarding significant events or other relevant information. However, not all staff working onsite attended these meetings. Staff told us they did not always receive feedback on significant events to ensure they were aware of learning outcomes. For example, we identified from speaking with staff that an incident occurred in the reception area and this was reported. We saw the event was logged in the significant event record. The staff member told us they had reported the incident but no further discussion or feedback had taken place. Therefore no direct action had been taken to reduce the risk of patients not being monitored effectively as a result of the incident.

We noted that reported significant events were displayed on a staff notice board, which included the outcomes to any investigations. However, there was no formal process to feed these back to staff or for learning to take place. The new system had improved the reporting of concerns but not ensured that all staff were aware of outcomes from significant events.

The significant event process had been improved since our inspection in August. However, the sharing of information following such events still required improvement and it was too early to determine whether the new system was effectively improving safety, openness and transparency.

Reliable safety systems and processes including safeguarding

The service had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. All clinical staff received level three safeguarding training and all other staff received level two.

There were localised policies in place with contact details for the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and staff were aware of who they should contact if needed.

Requires improvement

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nurses had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

At our inspection in August 2015 we found that PGD's had not been completed in accordance with legal requirements. (PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) They had been signed by the senior GP before the nurses required to administer the medicine had confirmed they had read, understood and were competent to administer the medicine the PGD related to.

In August 2015 we also identified that a number of shifts were covered by non-prescribing nurses. This meant the GP on duty had to authorise all prescriptions and any medicines administered by the nursing staff. Consequently patients had to wait until the GP was available and the nurse was able to obtain a prescription or authorisation. This delayed treatment for patients and extended the time that other patients waited to be seen.

At the inspection in October 2015 we saw all PGDs had been updated and were appropriately authorised to enable nurses to administer some medicines and vaccinations. We saw from the staff rotas we reviewed that 16 days prior to our visit there had been two GPs onsite for most shifts. This provided more support for nurses when assessing patients who may need prescriptions.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the service and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the service clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The service had a lead for infection control who had undertaken further training to enable them to provide advice on the service infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence audits were carried out and the last was completed in June 2015. No actions or issues were identified.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The service had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the service was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The service had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

Requires improvement

Are services safe?

Equipment

We saw staff had most of the equipment to enable them to carry out diagnostic examinations, assessments and treatments. However, staff raised concerns about the lack of appropriate lighting controls to enable them to carry out some eye examinations. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was in 2015. We saw evidence of calibration of relevant equipment had taken place since our last inspection including blood pressure measuring devices and medical scales.

Staffing and recruitment

At our last inspection in August 2015 we found treatment was being potentially delayed because the provider had not reviewed staffing to accommodate the demand for treatment of minor illnesses. The service advertised, via a prominent poster at the main entrance, that there was always a GP available throughout the opening hours of 8am to 8pm daily. However, when we reviewed the staff rosters from the start of July we found that there was not a GP on duty on the morning of Wednesday 1 July and the whole of Wednesday 29 July. Therefore nurses were working without supervision placing patients at risk of harm.

In October 2015 the operational manager told us about the arrangements for planning and monitoring the number and skill levels of staff required to meet patients' needs. We saw there was a rota in place including clinical staff with appropriate skills and qualifications. From 21 September to 7 October 2015 we saw there were usually two GPs on duty. One GP was listed as designated to treat patients presenting with a minor illness. Although we noted there was often no nurse prescriber on duty, the risks identified at the last inspection, which related to the lack of nursing staff with the appropriate skills, on duty had been reduced. This was due to the increase in nurses and an additional GP being available on most shifts. Nursing staff we spoke with told us the additional staff had improved the service since the previous inspection. We reviewed the skill mix of nursing staff and saw that most shifts had a nurse on duty with training in dealing with minor illnesses.

We found that reduced numbers of patients were being diverted to other services during September and October compared to the months prior to August 2015 due to a revised protocol for diverting patients. This was aimed at reducing the need for patients to attend A&E where it was more appropriate to be seen at the centre. This had an impact on the staff working at the end of the day. Staff told us that there was sometimes a backlog of patients waiting to be seen after 8pm meaning they had to work past the end of their shift. Nurses gave accounts of working past 9pm in order to ensure the backlog of patients were seen, although we saw from a chart of log-off times recorded at the centre that staff were still working past 9pm on only two occasions from 2 September to 7 October 2015. The rotas we reviewed indicated that GPs worked until 8.30pm and therefore there was a risk that nurses would be left onsite without GP support after this time. A full review of the staffing levels and cover at the end of the day had not been undertaken to ensure patients received safe care and treatment and staff were appropriately supported.

We noted a significant event reported on 3 September 2015 where a patient had been waiting for an ambulance to attend and a GP wrote a handover but did not provide the handover in person to the ambulance crew when they arrived. The written handover was passed to the ambulance crew by other staff. Therefore this patient was at risk of an incomplete handover and this was reflected in the significant event analysis we reviewed. The centre discussed this with the relevant GP and reminded them of their responsibility to their patients when passing care onto other services. The delay in the patient's ambulance was caused by the ambulance provider not Bracknell Urgent Care Centre. We also noted a second significant event, which identified how the handover to the out of hours service needed to be improved and made clear to patients. We were provided with no evidence to suggest there was a protocol for handover to ambulance crews.

We saw the provider's performance in relation key performance indicators had also improved in September. At the time of this inspection the provider was advertising nurse prescriber vacancies and they were also due to hold a recruitment open day a few days later.

At the inspection in October, we identified that all of the GPs were locums who had started working in the centre in September 2015. We noted that locum GPs had a very limited access to One Medicare Ltd policies and internal systems, which they needed to access supporting information in relation to the safety, care and treatment of patients. This included documents that related to a patient care, support and treatment. There was an escalation

policy in place to refer staff to clinical expertise available off-site, but this policy was provided to us after the inspection, so we could not verify this was available to the locum GPs who did not have access to many policies and procedures. Members of the senior leadership team told us that they had recognised the risks associated in using a high number of locum GPs.

The service had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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 centre employed high numbers of locum GPs and agency nurses. We saw that records for these staff had been maintained indicating all checks required had been undertaken.

Monitoring safety and responding to risk

The service had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the service. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The service also had a health and safety policy. The premises were maintained by another provider and as risks such as fire were administered by them. This included responding to any maintenance issues, such as broken glass in the roof of the building which was in the process of being fixed. The centre had also undertaken its own fire risk assessment with action to be completed later in 2015. There was a control of substances hazardous to health (COSHH) risk assessment which was generic for the building.

Arrangements to deal with emergencies and major incidents

The service had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the service and all staff knew of their location. These included those for the treatment of cardiac arrest, meningitis, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Reception had access to an emergency alarm call which would sound in the communal area of the shared building. Although this did not directly alert nurses or GPs working in the centre's consultation rooms, there were additional personnel including a security guard employed in the building to raise an alarm with clinical staff if needed. There was the ability to phone clinical staff in the office or treatment and consultation rooms. Due to a temporary maintenance issue, out of the control of the provider, the waiting area had been moved to an adjacent area where it was not in direct site of the reception desk. If a patient collapsed or needed medical attention it was possible the receptionists would not realise or call for assistance. The provider was aware of this concern and we were informed they had spoken with the provider who owned the building about changing the layout of the reception and waiting area. However, they had not made any temporary changes to protocols in the reception area or improvements to mitigate this risk whilst a layout change was being considered.

There was a disaster recovery plan in place that had been reviewed in March 2015. The plan identified risks to the continuation of delivery of services. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included IT failure, loss of premises, and loss of personnel. The policy stated that in the event of a shortage of GPs then GPs from elsewhere in the group will be transferred to the site and locum agencies should be contacted as last resort. However, the centre was predominately using locum GPs with occasional support from other GPs employed by the provider.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

At our last inspection in August 2015, we found that the risk of transferring patients to other services such as A&E had not been assessed and managed. This meant patients may have been diverted to A&E who were not well enough to travel independently or without medical assistance.

In October 2015, the centre had drastically reduced the number of patients being diverted from the centre. Receptionists told us they would never ask a patient to do so without them first being assessed by a nurse. We also looked at records where patients had been triaged close to 8pm when the centre was due to close. We found that none of the patients we reviewed had been diverted. Some patients were still awaiting ambulances for transfer to hospital when their needs could not be met by the centre, but they were not asked to travel independently where this was not appropriate.

We found the service carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We spoke with nurses about their assessments of patients and found they had an understanding of NICE guidance. There was a triage protocol and staff were aware the process and procedures to follow. Reception staff did not undertake the triage of patients but they had a process for prioritising patients with high risk symptoms, such as chest pain or hypoglycaemia.

However, clinical staff did not have access to pathways for treating specific conditions and relied on their skills and knowledge. Clinical pathways are often used in urgent care services where they enable staff to follow a set protocol. For example with a head injury. With so many agency and locum staff working at the service this would have been a measure that reduced the risk to patients by providing set protocols for locum GPs and agency nurses to follow.

In August 2015 we found that there was no evidence of a system in place to review the radiologists reports following x-rays undertaken by another provider onsite, or follow the results up with patients. Patients were at risk if the radiologist had found an issue of concern that the GPs and nurses then missed. In October 2015 we found that the service had systems to delegate daily tasks to appropriate staff, such as correspondence with GP practices regarding patients' treatment at the centre. There was an appropriate system for following up on x-rays. Nurses were designated the task of reviewing x-rays before the results were communicated with patients.

Management, monitoring and improving outcomes for people

The service produced monthly monitoring reports of the activity undertaken, which were shared with the CCG. These included reviews of the targets agreed with the CCG used to monitor the delivery of the contract at Bracknell Urgent Care Centre. In August 2015 we found the provider was regularly not meeting their targets for triage times (15 minutes for children and 30 minutes for adults) and the completion of a patient's treatment in four hours. During September 2015 there had been an improvement in the achievement against the targets. Triage times for children were met and for adults the centre missed the target of 80% of adults triaged within 30 minutes, achieving 78%. Nineteen patients had not had their treatment completed in four hours. A large proportion of the instances where 19 patients were not discharged in four hours were beyond the control of the centre, due to ambulances which had been called for the patients but there were significant delays in the ambulance attending. This was due to the ambulance service appropriately prioritising the centre's calls. In response to this concern the provider was in discussions with the local ambulance service to improve the situation.

There was minimal quality monitoring to identify improvements, such as clinical audit. Therefore, improvements were not always identified to ensure the necessary action was taken to improve patient outcomes. This limited the learning for staff and for the service overall to improve patient outcomes and care.

We noted some auditing was required as part of the contract monitoring. This included reviews of records to determine whether appropriate notes were being maintained and communications with GPs were taking place within specific timeframes. For example, in September 2015 98% of patients' consultation and treatment records had been forwarded to their GP within four hours or by 8am the next day. There was also reviewing of the potential impact of the centre on children's

Requires improvement

Are services effective?

(for example, treatment is effective)

attendances at A&E undertaken by the CCG and the centre. This indicated that between 2013/14 to 2014/15 there had been a reduction in children's attendances at A&E potentially as a result of the urgent care centre.

Effective staffing

In August 2015 we found that employed nursing staff were not supported in maintaining their continuing professional development and that the provider had an expectation that this would be completed in the nurses' own time. In October 2015, we found that staff rotas indicated nurses had some protected training time. From our discussions with employed nurses we found that they had the right training to care for both minor illness and minor injury.

The service had an induction programme for new members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. However, all of the new locum GPs were not provided with a robust induction or access to the provider's computer systems which would enable them to access support information and policies. This increased the risk of patients receiving poor care and treatment without the access to healthcare updates and information.

Regular meetings were not taking place other than the morning briefing. Staff told us the morning briefings included any operational or handover issues that staff may need to be aware of. However, these meetings were not attended by all members of staff, who also felt they would benefit from greater feedback and support. Staff were concerned about the lack of communication.

Senior clinical staff attended the centre to provide support on various dates during September and October 2015. The evidence presented to us did not demonstrate supervision for staff who may need additional support to make clinical judgements, such as locums, was available at all times.

A new lead nurse had been appointed and had commenced work at Bracknell Urgent Care Centre, in September 2015. The nurses we spoke with felt their support had improved. Staff reported that they had received appraisals. We looked at a staff training matrix and saw a number of core training courses were monitored through this tool. This showed staff were up to date with training or had a date booked for undertaking training when it was required. This included basic life support, Caldicott principles and safeguarding.

Coordinating patient care and information sharing

Staff worked with other providers by sharing information when people moved between services and by providing summaries of care provided to patients' GPs. The electronic record system enabled efficient communication with GP practices and other services.

Consent to care and treatment

Staff told us they always sought patients' consent to care and treatment and they referred to relevant legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). Staff had access to an MCA protocol and were provided with training.

Health promotion and prevention

Many the clinical staff working at Bracknell Urgent Care Centre had been newly appointed in the previous month. Subsequently, their knowledge of the health needs of the local and wider patient groups was limited. There were some relevant health leaflets and posters displayed around the centre. Information such as NHS patient information leaflets were also available. GPs told us they offered patients general health advice within the consultation and if required they referred patients to their own GP for further information.

Patients who may be in need of extra support were identified by the service. These included carers, homeless patients and those with sexual health needs. Patients were provided with information or signposted to relevant external services where necessary.

The service was not commissioned to provide screening to patients such as chlamydia testing. It was not commissioned to care for patients' with long term conditions such as asthma or diabetes. All patients who were eligible for smoking cessation advice were offered this.

The only vaccinations provided at the centre were for tetanus, diphtheria and polio. These were provided as needed and not against any public health initiatives for immunisation.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. Patients were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

All but one of 34 patient CQC comment cards we received were positive about the service experienced. All 14 patients we spoke with said they felt the urgent care centre offered an efficient service and that staff were helpful, caring and treated them with dignity and respect. Reception staff were specifically complimented for their efficiency and politeness.

The centre achieved a 75% satisfaction rate on patient satisfaction in the friends and family test in September 2015.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they 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. Patient feedback on the comment cards we received was also positive and aligned with these views. GP locums told us they had the time they needed to consult properly and listen to patients.

There was a translation service available for patients who did not have English as a first language. However, some staff we spoke with did not know this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The service website also listed a number of services including counselling and a local disability advisory service. Staff told us they had access to patient support materials on the internal IT system. In November 2014 the centre participated in 'Self Care Week' in a local shopping centre and is planning to do so again in November 2015.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service worked with the local CCG to plan services and to improve outcomes for patients in the area. No patients were registered at the service as it was designed to meet the needs of patients who had an urgent medical concern which did not require A&E treatment, such as life threatening conditions. The service was responsive to patients' needs in a variety of ways:

- Appointments were not restricted to a specific timeframe so clinicians were able to see patients for their concerns as long as they deemed necessary. This timeframe would be put under pressure during busy times.
- A translation service was available. However, not all staff were aware of how to access this for patients.
- Homeless patients could access the service.
- The centre attended local community events with stands and staff attending to promote the centre and work with local groups. For example, the centre was launching a health information hub in October 2015 to provide information and signposting to patients.
- A volunteer led support service was available at certain times for patients to assist in directing and supporting patients around the centre and any specific needs patients may have had.

The premises and services had been adapted to meet the needs of patients with disabilities such as automatic doors and all consulting and treatment rooms being on the ground floor. Height adjustable couches were available in the treatment rooms and access to treatment rooms was provided through wide corridors giving sufficient room for either wheelchairs or mobility scooters.

We saw that the patient waiting area had been out of use for over a month due to damage to the glass roof of the building. We were told by the operational manager that the materials to complete the repair were on order. This meant that the patient call system was unavailable. We saw both the GP and nursing staff called patients from the temporary waiting area for their assessment. This was carried out sensitively and enabled the GP or nurse to escort the patient to the treatment rooms.

Access to the service

The service was open between 8am and 8pm seven days a week. Patients did not need to book an appointment but could attend the centre and wait to see a nurse or GP. In September 2015 3056 patients attended the centre, compared to an average of approximately 2970 each month between June and August. Patients filled a form in when they arrived at the service which requested some personal data and reasons for the visit. The form also informed patients that their GP would be informed of the consultation and treatment received at the centre. The centre had a target of consulting, treating and discharging patients in four hours.

In August 2015, we found that adjustments to staffing and service delivery in respect of patient attendance data was not used to forecast and meet demand. We did not find an action plan in place to address the skill mix and staffing numbers in response to the change and increase in demand. The service had consistently missed its contractually agreed targets for seeing patients. There was a target to triage children in 15 minutes and adults in 30 minutes.

In October 2015 members of the management team told us that additional resources for clinical staffing had been secured for September. We reviewed the achievement against patient waiting time targets in September 2015 and noted improvements from July and August:

- 87% of children were triaged within 15 minutes (target 80%)
- 78% of adults were triaged within 30 minutes (target 80%)
- 19 patients were not discharged within four hours out of 3056 (target 100%). Staff accounted for some of the patients not discharged within four hours as those waiting for ambulances for very long periods of time.

Patients we spoke with were very complimentary about accessing the service. Comment cards also aligned with these views. Of the 14 patients we spoke with nearly all were happy with the time they waited for triage and eight out of nine patients we saw after triage were happy with their experience and waiting times. The majority of patients we spoke with were accessing the service during a period of low demand.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The service had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the service.

We saw that information was available to help patients make a complaint or comment on the service they received, through a leaflet displayed onsite. We looked at two complaints received in September 2015 and found that complaints were investigated and responded to appropriately.

Lessons learned from individual complaints had not been passed onto staff at the centre to ensure they were acted on to make improvements to the service.

Are services well-led?

Inadequate

(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 stated goal to place patients at the centre of their service delivery. There was a statement of purpose for the service. We saw the provider's corporate values were displayed prominently for patients and staff to see. The provider's website stated that they designed their services to ensure they were patient centered and that they worked in partnership with patients, staff and commissioners to explore emerging medical and technological innovations to shape changes in care delivery and improve services for our patients and our workforce.

Since the inspection in August 2015, the provider had continued to work very closely with the CCG to develop an action plan to address the previously identified concerns from May 2015 and new issues identified during the CQC inspections in August 2015.

We found that patient feedback was sought locally and a 'you said we did' board was displayed in the waiting area. However, nurses and receptionists employed at the centre did not have the opportunity to provide feedback via meetings and were not involved in the governance structure.

Governance arrangements

In August 2015, we found that the provider did not have a robust system in place to identify, assess and manage risk. Governance arrangements had not identified that the lack of sustained local leadership had left staff at the service feeling unsupported. The centre's staff found it difficult to respond to problems, such as low staffing levels, because the provider dictated that the service needed to consult with high level staff before implementing remedial actions or using resources. The provider had not acted to manage identified risks from commissioner reports and from staff.

In October 2015, we found that limited governance arrangements continued locally at the centre. The delivery of high quality of care was not always assured by effective governance procedures. Clinical governance meeting minutes included senior clinicians and managers from One Medicare Ltd who were not always present at the site and who did not provide patient services. Local Bracknell Urgent Care Centre staff were also not present at the provider governance meetings. Therefore staff who understood the provision of services at the centre were not involved in the governance arrangements or decisions.

Staff reported that there was a lack of support, specifically in relation to feedback when incidents or significant events were reported. We noted that reported significant events were displayed on a staff notice board, which included the outcomes to any investigations. However, the processes for communicating learning with staff did not ensure they received all information pertinent to their role.

There had been some improvement in communication arrangements with staff. Daily briefing meetings were held every morning which communicated information to staff such as who the clinical leads were for each day and some operational issues they needed to be aware of. Nursing staff were positive about the appointment of a lead nurse and told us they believed nurses meetings were being planned. However, the ongoing lack of structured meetings meant staff had limited means to formally learn from changes or investigations into circumstances relating to complaints or incidents. This also included amendments to protocols following significant events or changes in best practice.

Remote support meetings were held over the phone between senior clinicians at One Medicare Ltd and the operational manager who covered two sites for the provider in the south of England. Daily concerns regarding operational issues were discussed at these support meetings. This included issues such as referring patients for x-rays and staff rotas. There was no formal onsite support for clinical staff at the centre. Although there was access to external clinical leadership and expertise, with only locum GPs working at the centre there was a risk that staff did not have access to the support they may need. The centre was in the process of recruiting a new clinical lead at the time of the inspection and the new lead was due to start in mid-October.

The service had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the service. We looked at a number of policies and found they were accessible to employed staff. However, locum GPs and agency nurses did not have access via the computer system to these records. The provider had not assessed the safety risk if clinicians were not able to access key policies, procedures or

Are services well-led?

Inadequate

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

healthcare updates. The CQC GP specialist advisor raised this concern with the group medical director on the day of inspection. They acknowledged the difficulties this could present for locum GPs needing access to key information about the service and local care arrangements. For example, how to make timely referrals to other services and safeguarding teams.

Some of the policies we reviewed were generic provider wide policies and did not reflect the circumstances and services provided at Bracknell Urgent Care Centre. For example, the infection control policy did not refer to the layout of the premises or clinical areas at the site and referred to protocols related to treatment which did not take place at the service.

There was limited monitoring of clinical performance. We found there was no programme of audit to review the clinical work undertaken at the centre, to determine if any improvements to patient care could be identified and implemented. The only auditing of the centre in terms of patient outcomes was around the target indicators agreed by the CCG.

We identified that risks were not always identified and dealt with swiftly. For example, the risks to patients due to limited visibility of the waiting area were not dealt with by interim measures whilst the centre relocated its waiting area temporarily. The risk of locum GPs not being able to access pertinent information in the delivery of care was not identified.

Leadership, openness and transparency

In August 2015, we found that staff did not feel the leadership team were engaged with the way they worked. The centre had operated without a senior nurse since April 2015 and the regional medical director had not been available since 21 July 2015.

In October 2015, we noted that there was a limited local leadership structure with named members of staff in lead roles. For example, there was a new lead nurse and a business manager. A medical director for Bracknell Urgent Care Centre was still to be appointed. As an interim measure, a medical director from another One Medicare Ltd urgent care centre provided remote clinical support. However, the local management and staff with lead roles were a new team. Senior leaders from One Medicare Ltd had often visited Bracknell Urgent Care Centre, since the August inspection to provide additional support.

We found that a lead nurse had been employed at the centre and this had been received positively by the nursing team. There was a business manager who had been part of the leadership team since July 2015. The nurse lead and business manager informed us that they had communicated openly and honestly with the provider and local CCG to inform them of the requirements to improve the service's poor performance in terms of KPIs. They told us that they had identified the resources needed to improve the performance and that staffing levels had improved. Staff members were clear about their own roles and responsibilities.

Staff had access to a whistleblowing policy but this did not contain information on the rights of whistleblowers and how they should escalate concerns externally. It only contained guidance for staff on how to report concerns internally.

At the last inspection in August 2015 there was a top down culture, with staff and whistleblowers reporting poor leadership and management which led to claims of bullying and discrimination. Staff reported concerns and these were not always responded to. Some staff felt they were not treated with respect, when they did report concerns. Since the inspection in August we were contacted by three whistleblowers regarding a lack of support and concerns about the behaviours of some senior staff from One Medicare Ltd.

During the inspection in October, we found from speaking with employed staff that there had been an improvement in the working conditions at the centre. Specifically, staff reported that improvements were seen following the appointment of the lead nurse.

The cultural concerns identified at the previous inspection were linked to the provider and the impact upon the management of Bracknell Urgent Care Centre. Due to the high numbers of new locum GPs and agency nurses we were unable to monitor any changes in culture. Particularly, when many staff had worked at the centre for a short time and therefore they were unable to comment on the approach of the provider in terms of the overall management. However, the new staff we spoke with on the day of inspections did not raise any concerns.

Are services well-led?

Inadequate

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

Healthwatch informed us that they had been trying to meet with the centre to discuss patient feedback for nine months but each time this was planned the centre cancelled the meeting. They also found it difficult to gain information from the service when they requested this.

Seeking and acting on feedback from patients, public and staff

There was some engagement with people who used the service. The service had gathered feedback from patients through the small patient participation group (PPG), surveyed 10% of patients who use the service regularly and took part in the friends and family test. We saw an example that the service acted on feedback from patients when this was received. For example, there had been adjusting the way the patient an information screen was presented.

However, following the inspection visit we spoke with Bracknell Forest Healthwatch who provided us with a log of feedback regarding the centre over five months preceding the inspection. This related to waiting times, patient experience and processes and the centre.

Management lead through learning and improvement

We saw staff had some time to maintain their clinical professional development through training. We saw from staff files that appraisals took place.

This section is primarily information for the provider

Enforcement actions

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and social care act 2008 Regulated Activity Regulations 2014 Regulation: 17 Good governance The provider was not assessing, monitoring and improving the quality and safety of the service because limited clinical audit was taking place. The provider was not improving the service once they had evaluated information relevant to good governance. Regulation 17(1)(a)(b) · The provider had not involved staff in significant event or incident outcomes. · Staff were not suitably supported in their roles or involved in governance. · There was no monitoring of clinical care and treatment