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.

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out two unannounced focused inspections of Bracknell Urgent Care Centre on 17 and 24 August 2015. The inspections were carried out because we had received information of concern from whistleblowers and the local clinical commissioning group (CCG) in relation to patients being placed at risk. These concerns referred to insufficient staff or lack of experienced staff to deal with patient demand and meet safe waiting times. In addition there were concerns that prescribing of medicines was being delayed due to a lack of staff qualified to prescribe. We were also informed that staff turnover was high and the service was heavily reliant on locum staff. Both inspections were in response to information of concern.

We found the service was not meeting fundamental standards and had breached regulations.

Our key findings were as follows:

- Patients were placed at risk of harm because there were insufficient or inappropriately skilled staff on duty to carry out a robust assessment of patients' needs. Patients were not being assessed and treated in a timely manner.
- Medicines were not always managed safely and in accordance with legal requirements.
- Local managers were not given authority to deploy staff in sufficient quantity or of appropriate experience to support safe and responsive delivery of patient care.
- Staff received inconsistent support and training to carry out their duties.
- Learning from reported incidents was not shared in a robust manner with staff to avoid recurrence.
- Staff were fearful of reporting incidents and concerns for fear of reprisal.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Patients were treated in a clean and tidy environment and their privacy was respected.
- The centre was open between 8am and 8pm every day offering a service to patients at times when their GP practice was closed.
- People working in Bracknell and surrounding areas were able to access a minor injury and illness service whilst away from their local GP.
- The service ran from a purpose built clinic that afforded easy access to patients with a disability.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Provide adequate support and training for all members of staff, which allows them to undertake their role and meet the demands of the service.
- Ensure that appropriate levels of staffing are maintained at all times to maintain the safe and effective delivery of services. A GP must be on duty at all times during service opening hours.
- Ensure systems and plans are in place to enable staff at the service to organise prompt cover in the absence of GP or a nurse.
- Ensure clinical advice from senior GPs can be obtained in a timely manner.
- Ensure medicines are managed and administered safely. Introduce patient group directions that follow legal requirements and instigate checks on all medicines to ensure they are in date and fit for use.
- Ensure a mechanism to encourage staff to report concerns and incidents is operated consistently and fairly is in place. Investigate and respond consistently to issues and concerns raised by staff.
- Improve the system of communicating learning from significant events to ensure all staff at the service are equipped to avoid recurrence of incidents that have placed patients at risk.

The areas where the provider should make improvement are:

- Implement a system to review x-ray reports from radiologists and take appropriate action on the findings of the report.

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?

Staff knew how to report incidents but they were fearful about doing so. Although the service carried out investigations when things went wrong, lessons learned were not communicated consistently and so safety was not improved. Patients were at risk of harm because systems and processes to manage medicines had weaknesses. There were times when care and treatment decisions placed patients at risk because there were insufficient numbers of staff with the relevant experience and skills on duty.

Are services effective?

Audit of patient outcomes and service quality were undertaken and these identified areas where the service could make improvements. However, there was no evidence of action having been taken to address the issues identified. There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.

Are services caring?

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 in an environment that made this difficult.

Are services responsive to people's needs?

Although the provider had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all patients who may need to access the service. The service was equipped to assess and treat patients and meet their needs however, it did not always do so in a timely manner. Patients could get information about how to complain in a format they could understand.

Are services well-led?

There was a strategy to put patients at the centre of service delivery and a commitment to delivery of safe care and treatment. However, staff we spoke with told us they did not feel supported in delivering the strategy. There was a lack of robust local leadership and staff did not feel supported by senior management. The provider held regular governance meetings but outcomes from the governance meetings were not communicated consistently. Some staff had not received regular performance reviews and did not have clear

Summary of findings

objectives. Decision making to support delivery of safe and effective care was undertaken at provider level and local managers were not given authority to ensure appropriate resources were deployed to maintain safe delivery of services. There was a management structure which was top down and directive. Some staff reported concerns that they felt bullied, harassed and discriminated against. We found that staff concerns were raised in respect of these matters but appropriate action had not always been taken.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Action the provider MUST take to improve:

- Provide adequate support and training for all members of staff, which allows them to undertake their role and meet the demands of the service.
- Ensure that appropriate levels of staffing are maintained at all times to maintain the safe and effective delivery of services. A GP must be on duty at all times during service opening hours.
- Ensure systems and plans are in place to enable staff at the service to organise prompt cover in the absence of GP or a nurse.
- Ensure clinical advice from senior GPs can be obtained in a timely manner.
- Ensure medicines are managed and administered safely. Introduce patient group directions that follow legal requirements and instigate checks on all medicines to ensure they are in date and fit for use.
- Ensure a mechanism to encourage staff to report concerns and incidents is operated consistently and fairly is in place. Investigate and respond consistently to issues and concerns raised by staff.
- Improve the system of communicating learning from significant events to ensure all staff at the service are equipped to avoid recurrence of incidents that have placed patients at risk.

Action the service COULD take to improve

- Implement a system to review x-ray reports from radiologists and take appropriate action on the findings of the report.

Bracknell Urgent Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team at the first inspection on 17 August 2015 was led by a CQC Lead Inspector**.** The team included a GP, the CQC national nurse advisor, a practice manager advisor and a second CQC inspector. The second inspection on 24 August 2015 was led by a CQC Inspector accompanied by the CQC regional GP Advisor.

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 practice elsewhere. It is commissioned by the Bracknell and Ascot Clinical Commissioning Group (CCG).

The service is one of eleven GP 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 service is commissioned to offer assessment, care and treatment for both minor illnesses and minor injuries. There are three part time salaried GPs, five employed nurses and a small team of reception staff. Additional staff are supplied via a contract with a locum agency. 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 and 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 111.

The service operates from:

Brants Bridge Clinic

London Road

Bracknell

RG12 9GB

Why we carried out this inspection

We carried out these inspections in response to concerns raised by the local CCG and whistleblowers relating to insufficient staff being available to deliver safe care and treatment in a timely manner.

The first inspection took place with a team that consisted of two CQC inspectors, a GP Advisor, a CQC practice manager advisor with experience in out of hours services and the CQC National Nurse Advisor. We spoke with patients who used the service to help us capture their experience. The second inspection was carried out by a CQC Inspector and a GP Advisor and we spoke with two members of staff and a GP. We also spoke with three members of staff by telephone following the inspections because they were not on duty at the time of inspection.

The service had regularly missed achieving waiting time targets since it opened and the CCG reported their

concerns that this placed patients at risk. The CCG had carried out inspections in May 2015 and subsequently met with the provider to present their findings and seek action to address issues they identified relating to the safe and prompt delivery of service to patients. The provider produced an action plan for the CCG and had assured them that measures would be put in place to improve patient safety and waiting times. The CCG shared their concerns with the Commission in early August 2015. CQC had also received information of concern from whistleblowers referring to staff shortages, lack of support from senior management and high staff turnover which they felt placed patients at risk because there were not enough staff on duty to deliver a safe and prompt service.

Between the first and second inspections we received further information from a whistleblower telling us that significant events were not being reviewed thoroughly and that actions identified to prevent similar occurrences in the future were not always reported back to staff at the service. We heard that staff concerns over staffing levels were not being followed up and that staff were fearful of raising concerns for fear of reprisal.

The information we received and our findings from the inspections, detailed in the inspection report that follows, gave rise to significant concern. On 26 August 2015 we issued the provider with a letter setting out our concerns and asking them to produce evidence of actions they had, or would take, to address both the findings of the inspection and previous inspections undertaken by the CCG. The provider gave a commitment to complete the actions they had told the CCG they would take and to ensure there was always a GP on duty along with sufficient, relevantly qualified, staff to maintain a safe and timely service. The commission found that some of the actions the provider had said they had taken had not been completed.

How we carried out this inspection

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

Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

During our visits, on 17 and 24 August 2015, we spoke with staff that were on duty including the registered manager, the business manager, a GP, three locum nursing staff and two members of the reception staff. Following the inspections we spoke with three further members of staff including two nurse practitioners and another member of the reception team. We spoke with 13 patients during the visit to obtain their views on the service they received.

We reviewed a range of policies and procedures the service used to govern their activities, reviewed how medicines were kept and managed, We reviewed staffing rosters, logs of significant events and minutes of meetings. We inspected the premises to look at the cleanliness and the arrangements in place to manage risks associated with healthcare related infections.

We spoke to the local CCG and received information from them in relation to their formal meetings with the provider to monitor delivery of the service.

Are services safe?

Summary of findings

Staff knew how to report incidents but they were fearful about doing so. Although the service carried out investigations when things went wrong, lessons learned were not communicated consistently and so safety was not improved. Patients were at risk of harm because systems and processes to manage medicines had weaknesses. There were times when care and treatment decisions placed patients at risk because there were insufficient numbers of staff with the relevant experience and skills on duty.

Our findings

Safe track record

Bracknell Urgent Care Centre received safety alerts from One Medicare Ltd's head office and it was the responsibility of local management to ensure action was taken. Medicine alerts were passed to GPs and nurse prescribers and action was taken to ensure medicines prescribed complied with the alerts. We noted that the service was not responsible for prescribing repeat or regular medicines and that any action arising from an alert related to avoidance in prescribing a new medicine for the patient. Safety alerts relating to equipment were disseminated by the business manager. There were records showing that senior officers of One Medicare Ltd undertook quarterly safety inspections. The reports from these inspections identified actions. For example, in June 2015 the provider identified that the service did not have an accident reporting book in place. During our inspection on 17 August 2015 we saw the accident reporting book was available to use. There was evidence that the provider had responded to earlier safety concerns relating to staffing levels at weekends. The number of nurses on duty at weekends had been increased from two to three in the last six months.

Induction training and the mandatory training package for staff covered various aspects of health and safety including, fire safety, control of substances hazardous to health (COSSH) and lone working.

Learning and improvement from safety incidents

The service had a system in place for reporting, recording and monitoring significant events. All staff were aware of their responsibility for reporting significant or critical events and our conversations with them confirmed this. We reviewed the significant event logs and these showed that staff of different grades and disciplines had completed significant event reports. However, staff we spoke with told us they had not submitted reports covering all their concerns 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. However, there was evidence that the operational manager was seeking cover for the absent GP but this was not recorded as a significant event. Staff we spoke with told us that seeking cover without approval could result in disciplinary action.

Are services safe?

We also reviewed provider level significant event summaries and saw these had been taken to the providers' integrated governance committee between April and June 2015. The committee was responsible for reviewing and acting upon reported events. The minutes of the meetings showed us that the governance group identified any trends in events. However the summary of significant event reviews did not detail action that the service should take to avoid similar occurrences in the future. Staff we spoke with told us that they did not always receive feedback from the provider on significant events they had reported. The registered manager told us that feedback was to staff via e-mail or at briefing meetings. The information we received from staff showed us this feedback was inconsistent. Significant events were used as an organisation learning tool but not always communicated to front line staff delivering the service.

We also reviewed three significant events that had been submitted by staff at the centre between 1 August and 18 August. One of these related to a serious concern regarding possible discrimination in terms and conditions. The provider sent us the minutes of the integrated governance committee held on 20 August 2015. There is no record in the minutes of the provider's corporate governance committee held on 20 August 2015 of receipt of significant event reports from BUCC. Therefore, we saw no record of receipt, review or action identified for the three significant event reports we reviewed.

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 in post for over three months had received relevant role specific training on safeguarding. We noted that the employed GPs and nursing staff had been trained to level three in child safeguarding. This level is required for GPs and was one level above that required by nursing staff. The service checked that locum staff had the appropriate level of safeguarding training.

Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were able to reassure us they knew where to find the contact details for the safeguarding lead and we saw this information displayed on the staff notice board. The details of how to contact the relevant agencies in working hours and out of normal hours were also displayed and staff knew where to locate these. A senior clinician employed by the provider was appointed as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding.

Medicines management

We checked medicines kept in the medicines cupboard and medicine refrigerator 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 fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

All the medicines held in the refrigerator were in date and fit for use. During our first visit on 17 August 2015 we found two medicines held in the medicines cupboard were out of date. Although there was a policy and procedure for checking medicines this was not operated consistently and staff we spoke with were unclear who held responsibility for undertaking the checks. On our second visit we found the out of date medicines had been removed. There was no record of replacements being ordered or of a risk assessment to determine whether these medicines were essential stock.

Responsibility for generating and signing prescriptions lay with the GP on duty when there was not a nurse prescriber working. Prescriptions were handed to patients to take to pharmacies were therefore appropriately generated and signed before they were given to the patient. Prescription forms for use in printers were handled in accordance with national guidance as these were kept securely before issue to the GPs. Each day the blank prescriptions were placed in the printer when the service opened. The blank prescriptions that were not used during the day were taken from the printer and securely stored in a locked cupboard when the service closed.

We noted that most nurses either employed or locum nurses undertaking duties were not qualified to prescribe and required. This meant that for over 50% of the time the service was open the GP on duty had to authorise all prescriptions and any medicines administered. Consequently nurses had to wait until the GP was available to obtain a prescription or authorisation thus delaying treatment for the patient and extending the time other patients waited to be seen.

Are services safe?

We saw that a set of Patient Group Directions (PGDs) had been produced for a range of medicines that the nurses may need to administer (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). However, we noted that the draft PGD's had not been completed in accordance with legal requirements. 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. There was no evidence of staff competence to administer the medicines referred to in PGD's being checked and no records of training in administration of medicines. The provider's action plan presented to the CCG in June stated that PGD's were ready to be implemented but evidence from the two inspections showed that this was not the case after two months had passed.

On 17 August 2015 we witnessed one of the locum nurses on duty collect an immunisation for administration to a patient. The nurse did not seek authorisation from the GP on duty. The immunisation was therefore administered without legal authorisation from a qualified prescriber and without a PGD in place. Patients may have been put at risk because legal requirements for the administration of medicines were not being followed.

Cleanliness and infection control

The centre was visibly clean and tidy. There were cleaning schedules in place and the quality and frequency of cleaning was monitored on a daily basis. Patients we spoke with commented positively about the cleanliness of the environment.

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, aprons and coverings were available for staff to use. Staff told us there was sufficient protective equipment and that they used this when conducting intimate examinations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The provider had a lead for infection control who had undertaken further training to enable them to provide advice on the infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. The service had been open for 16 months and an infection control audit had been carried out.

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 owners of the premises had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We observed contractors undertaking water sampling and hot and cold water temperature checks on the day of inspection. This showed us that control measures were being followed to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had essential equipment to enable them to carry out diagnostic examinations, assessments and treatments. We were told that this was not the case when the service first opened. GPs we spoke with told us they had requested a slit lamp and dimmer switches to enable them to carry out some eye examinations but this equipment was not available on the day of inspection. We noted that all the equipment in use was due a calibration test as it had passed the one year guarantee period. We were assured that calibration was programmed to take place before April 2016 to comply with manufacturers' service schedules.

All portable electrical equipment had been safety tested in April 2015. There was a maintenance programme in place for the service premises and the NHS Trust landlords held records confirming that essential maintenance had taken place.

Staffing and recruitment

The provider had a recruitment policy that set out the standards it followed when recruiting all grades and disciplines of 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. We noted that all employed staff were subject to 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 service relied upon a high level of locum staff to ensure the required numbers of staff were on duty. We found the provider had an agreement in place with a locum agency. This included the requirement for the agency to undertake the necessary recruitment checks on staff supplied to the service. We reviewed records that showed us the provider also undertook a double check to ensure locum staff were appropriately qualified registered and vetted before they were allowed to work. There was a locum information pack and an induction checklist which new locum staff were required to complete before their first duty commenced. The registered manager told us, and three of the locum staff confirmed, that some locum nurses worked at the service regularly. This meant they had knowledge of the systems, policies and procedures in operation at the service.

Staff rosters we reviewed from 1 June to 24 August 2015 showed that under 50% of nursing duty shifts did not have a nurse prescriber on duty. We also saw that there was not always a nurse on duty with up to date training in dealing with minor illnesses. We were told that a minor illness update had been prepared for presentation to nurses to enhance their skills in this area. This training was not delivered and the lack of up to date experience in dealing with minor illnesses meant the GP was often called upon for advice or the patient had to wait to see a suitable qualified nurse or the GP. Treatment was delayed because the provider had not reviewed staffing to accommodate the demand for treatment of minor illnesses.

We were shown minutes of the provider's Integrated Governance Committee held in June 2015. The committee had recognised the risks of high usage of locum staff and we saw that performance of locums had been monitored to ensure that only those with appropriate skills and experience were booked.

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. Staff we spoke with shared their view that this compromised patient safety. We reviewed the company procedure for obtaining staff cover in the event of a GP or nurse not arriving for their duty. This required the centre manager, or a member of staff acting on their behalf, to seek formal approval from the provider head office to source a locum or bring in another employed member of staff to cover the absence. Staff reported that it was even more of a challenge to seek approval after 5pm and at weekends, when the head office was closed. This delayed obtaining cover and resulted in the absence of a GP on duty on the two dates we identified. The concerns relating to absence of GPs on duty and the failure to delegate authority to source clinical cover were relayed to us by both the whistle blowers who contacted CQC.

Subsequent to our inspection we contacted senior managers from the Bracknell and Ascot Clinical Commissioning Group (CCG). This organisation commissioned the services from the centre. They advised us that there was a contractual requirement upon the centre to have a GP on duty throughout the services opening hours. The CQC GP reviewed patient records from the two days when GPs had not been on duty at the service and found four examples of patients being placed at risk from the advice they had been given from the nursing staff on duty at that time. One patient had been advised to go the local A&E with a relative in their car. The risk of transfer by car had not been assessed. The provider had not adequately assessed the risk arising from loss of personnel and the effect it had on the timely and safe treatment of patients.

There was also evidence of the provider recruiting a member of staff who had a requirement for supervision placed upon them by a professional body. This member of staff could only be supervised by one other senior member of staff. A risk assessment had not been undertaken to determine how this member of staff could continue in their role if their supervisor reduced their hours or left the service.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff in post for more than three months had received training in basic life support. The provider checked that locum staff were also up to date with training in basic life support. Emergency equipment was available including access to oxygen and

an automated external defibrillator (used in cardiac emergencies). We checked that the pads for the automated external defibrillator were within their expiry date. Staff who had been in post for more than three months, and the locum staff we spoke with, all knew the location of the emergency equipment. We noted that the equipment was subject to checking and that these checks were recorded. However the recording was inconsistent. For example, the records showed that the equipment was checked on a weekly basis in April and May and yet there was only one check recorded in month of July. The registered manager told us the checks should be carried out once a week. The provider had not operated their equipment checking procedure consistently.

Emergency medicines were easily accessible to staff in a secure area of the practice and the majority of staff knew of their location. These included those for the treatment of cardiac arrest, 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.

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. We noted that loss of personnel was rated as low risk. Yet staff rosters we reviewed showed that there had been two occasions in July, the 1st and 28th, when a GP was not available on site. We also saw three significant event reports between 13 and 18 August reporting the use of the redirection policy sending patients to other services when the staff on duty could not cope with the number of patients waiting to be treated. Staff told us the redirection policy had been implemented before and not been recorded as a significant event. The CCG report of their monitoring visit in May 2015, that we received, corroborated this.

A fire risk assessment had been carried out by the owners of the premises and we noted that firefighting equipment and the fire alarm system had been serviced in accordance with manufacturer's instructions. Fire escape routes were clearly identified and maintained. There were no records of a fire drill having taken place. However, the provider shared the premises with NHS trust services and the fire alarm system covered the entire premises. A fire drill would require co-ordination with the other occupants of the premises.

Are services effective?

(for example, treatment is effective)

Summary of findings

Audit of patient outcomes and service quality were undertaken and these identified areas where the service could make improvements. However, there was no evidence of action having been taken to address the issues identified. There was limited recognition of the benefit of an appraisal process for staff and inconsistent support for any additional training that may have been required.

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found

from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs.

Due to technical difficulties the GPs and nurses at the service were unable to access patient summary care records (SCR) (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). The registered manager told us that the technical problems had only recently been resolved and that access to SCR information would be available in the near future.

Management, monitoring and improving outcomes for people

Patient comments demonstrated that they were satisfied with the care and treatment received

from the GPs and nurses at the service. They did however comment about the time they had to wait to be seen and the minimal information they received about how the triage process worked. All records for patients attending the service were sent to their own GP electronically immediately or by 8am the following day. This ensured that GPs were aware of their patient's attendance at the service and any tests that were carried out.

The service produced monthly monitoring reports of the activity undertaken, which were shared with the CCG. These included auditing whether patient attendance at the service was appropriate, demonstrating appropriate prescribing and reporting frequent attenders. We looked at the records for the months of February to July 2015 and saw that the provider was meeting the audit standards for these criteria. We also saw that advice to register with a GP was given to over 90% of unregistered patients during the six months February to July 2015.

The GPs at the service had conducted a monthly review of patients' notes with One Medicare Ltd's regional medical director until the director moved to a part time contract in

Are services effective?

(for example, treatment is effective)

February 2015. The results showed good performance in ensuring relevant information was included in the patient notes for onward transmission to the patient's registered GP. The monthly review of patients' notes had not taken place since March 2015.

Effective staffing

We reviewed staff training records for five employed staff these showed that staff who had been employed for over three months had completed mandatory training including basic life support and safeguarding. The two GPs employed and the employed nursing staff were all trained to the appropriate level in safeguarding children (level 3). The provider checked that locum nursing staff had also received both basic life support and safeguarding training. Staff who had worked with the service for less than three months were not required to complete mandatory training until their three month review period had been concluded. Staff received an induction that covered health and safety essentials including fire safety and maintaining confidentiality. New members of the nursing team also received an introduction to reducing the risks associated with health related infection. All staff received a copy of the provider staff handbook on their first day of duty. Training records were held centrally and the business manager received a monthly update on the training status for all employed staff.

The GPs employed were up to date with their yearly continuing professional development requirements or 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). We did not see any evidence of clinical supervision taking place with either the GPs or the nurses.

We were told the 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. We saw that these staff had attended one half day of training organised by the CCG and had also completed the provider's mandatory health and safety training.

At the time of inspection the service was operating without a Clinical Nurse lead. The new appointee was due to commence work with the service in late September. The regional medical director had not been available since 21 July 2015 and GPs were required to contact the national medical director if they required clinical advice or guidance. GPs we spoke with reported their concerns about accessing remote support if the required clinical advice. They told us they felt uncomfortable about requesting such support.

We reviewed staff rosters for six months and activity data from the months of July and August. These showed us that there was not a system in place to respond to peaks in demand on the service. We found that the service operated with the same number of staff throughout the opening hours for 90% of the six month period. The activity data we reviewed showed that the service experienced higher demand between 6pm and 8pm on weekdays and at weekends. There was no evidence of staff availability being adjusted to meet the peaks in demand. For example, on 90% of weekdays there was a GP and two nurses on duty during the morning when patient demand was at its lowest. Activity data reviewed for one week showed fewer than nine patients attending the service each hour between 9am and 12pm each weekday. However, from 6pm to 8pm there were over 12 patients attending each hour when the same number of staff were on duty. The significant event reviews we looked at showed the service had implemented their redirection procedure on three occasions during an eight day period from Thursday 13 August because staff were unable to meet the see and treat targets between 7pm and 8pm. We noted that urgent assessments were undertaken at these times based on the information given by patients at time of checking in. Staff availability was not adjusted to meet patient demand. Patients were at risk because they were not assessed promptly or were redirected to alternative services after a brief assessment of their needs.

During our inspection on 17 August 2015 we found that staff had been left an instruction on Friday 14 August not to redirect patients. This had resulted in the service coming under pressure on the weekend of 15 and 16 August when every patient who attended, including those that did not meet the service criteria, was assessed and treated.. For example patients wanting a wound dressing changed. Staff we spoke with told us they had sought clarification of the instruction but had found difficulty in obtaining clear guidance from the One Medicare Ltd manager on call over

Are services effective?

(for example, treatment is effective)

the weekend. We were told that the waiting time for patients attending for appropriate reasons had been affected because staff were treating patients who should not have attended the centre.

Working with colleagues and other services

We noted the close working between the service and the x-ray department located in the same premises. Both GPs and nurses were able to request x-rays and received the developed x-rays back in a timely manner. We were told that there was a reporting system which required the radiologists to review the x-rays and provided a report to the service within two days after the x-ray had been taken. There was no evidence of a system in place to review the radiologists report or follow this up with patients. Patients were at risk if the radiologist had found an issue of concern that the GPs and nurses had missed when they first reviewed the x-ray and made clinical decisions based on their own findings.

Information sharing

Staff used an electronic patient record computer system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This system was able to link to the computer systems in use at most GP practices enabling the service to share information with the patient's registered GP.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they would put their knowledge into practice.

Are services caring?

Summary of findings

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 in an environment that made this difficult.

Our findings

Respect, dignity, compassion and empathy

We spoke with 13 patients during our visit. All the patients were complimentary of the nurses and GPs. Some of the patients had visited the centre before and confirmed that they had received compassionate, kind and caring treatment they had received on previous occasions.

We noted that the centre shared a reception area with other users of the premises. This made maintaining confidentiality at the reception desk difficult. However, we saw that the centre used a booking in procedure which required patients to complete a short questionnaire and hand this back to the reception staff for details to be entered on to the record system. This reduced the risk of patient details being overheard by staff working for other organisations who shared the reception facility.

We observed that consultations and treatment with both the GP and the nurses took place in the privacy of a consulting or treatment room. Doors were closed during consultation and discussions between the patient and staff could not be overheard.

Some building work was being undertaken in the main waiting area at the time of inspection. This meant that patients were required to wait some distance from the consulting rooms and the patient call screen was obscured. The GPs and nurses had to call the patients from the waiting area and some of the patients we spoke with told us they were unhappy to have their names called in front of other patients.

We looked at the 8 reviews of the service on NHS choices since April 2015. These showed the majority of patients were pleased with the service they received from the centre and were appreciative of the care and advice received from the GPs and nurses. Three patients were negative about the support they were offered by reception staff specifically stating that they did not receive information about the waiting time and how the assessment and treatment process worked.

Care planning and involvement in decisions about care and treatment

The 13 patients we spoke with all said they were given information they understood from both the GP and the nurses to support their care and treatment. They told us that proposed treatment was discussed in detail with them

Are services caring?

and that when treatment options were available these were also discussed. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about their treatment.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with told us they were appropriately supported and offered information about what to do should their condition change or worsen, as well as information about how to support their recovery. Some patients told us that the staff were very helpful when treating young children and treated these patients in an age appropriate manner to assist with their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Although the provider had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all patients who may need to access the service. The service was equipped to assess and treat patients and meet their needs however, it did not always do so in a timely manner. Patients could get information about how to complain in a format they could understand.

Our findings

Responding to and meeting people's needs

We found that the service was not always responsive to patients' needs. The service was contracted to a set of access targets. These included 80% of adults to have first contact with a nurse or GP within 30 minutes of checking in. Eighty per cent of children to have first contact with a nurse or GP within 15 minutes of checking in and 100% of patients to have been seen and discharged within four hours. We were shown the achievement reports for these targets from February 2015 to the date of inspection. The reports showed that 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. For example in April 2015 only 64% of adult patients saw a GP or nurse within 30 minutes and in July 2015 only 74% of children were seen within 15 minutes. The data we saw for August 2015 showed 14 patients had not been discharged within four hours of checking in.

We saw records that showed the service had been established to deal with 29,000 patient contacts each year. The actual number of contacts in the year April 2014 to April 2015 had exceeded 32,000. This demonstrated the service had seen just over 10% more patients than had been forecast. We also noted that the service had been given an expectation of treating a patient case mix of 72% minor injuries and 28% minor illnesses. Data from the services records showed the actual split of minor injuries to minor illnesses in the last two months had been 52% to 48%. Adjustments to staffing and service delivery in respect of this data had not implemented and the provider continued to operate the service on the staffing levels initially set to meet forecast 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.

Tackling inequity and promoting equality

The provider had access to a telephone translation services. Some staff also spoke different languages. The service did not provide equality and diversity as part of the mandatory training package.

The premises and services had been adapted to meet the needs of patient with disabilities such as automatic doors

Are services responsive to people's needs?

(for example, to feedback?)

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 via wide corridors giving sufficient room for either wheelchairs or mobility scooters.

We saw that the designated space for patient waiting had been out of use for over a month due to damage to the glass roof of the building. We noted that the materials to complete the repair were on order. This meant that the patient call system was unavailable, because it was obscured by a scaffold, at the time of inspection. We saw both the GP and nursing staff go to the temporary waiting area and call patients for their assessment. This was carried out sensitively and enable the GP or nurse to escort the patient to the treatment room.

Access to the service

The service operated from 8am to 8pm every day of the year. Information on how to access the service was available on the provider website, NHS Choices website and was available from GP practices in the area. This included how to access the service and the range of services available.

Appointments did not have a set time, although there was a target of four patients to be seen per hour per nurse and GP. Patients were given as much time as they needed with clinicians for their needs to be met. Patients we spoke with told us they could get to the service quite easily. They also told us they had no difficulty parking and in gaining access to the service. The opening hours of the service meant that patients who had not been able to see their GP during practice opening hours could attend for assessment and treatment in the early evening. The service was also accessible to people who commuted to work in the area but lived and were registered with a GP elsewhere. This group of patients could attend at any time between 8am and 8pm if they fell ill at work or had a minor injury sustained during their working day.

Listening and learning from concerns and complaints

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

During the period from April 2014 to the day of the inspection the service had had a total of four complaints. These complaints had been fully investigated. We were able to evidence that staff had been briefed on complaints and action taken to avoid recurrence. For example staff were instructed to use a specific dressing to improve management of certain types of wound. The complaints were fully recorded and we saw they were reported to the provider and were discussed at provider level governance meetings. We saw the investigations into the complaints were thorough and impartial and that an apology was issued to the patient along with the response to their concerns. We noted that responses to complaints were not checked for accuracy before they were sent because one response referred to a negative outcome for the patients recovery after treatment.

Are services well-led?

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

Summary of findings

There was a strategy to put patients at the centre of service delivery and a commitment to delivery of safe care and treatment. However, staff we spoke with told us they did not feel supported in delivering the strategy. There was a lack of robust local leadership and staff did not feel supported by senior management. The provider held regular governance meetings but outcomes from the governance meetings were not communicated consistently. Some staff had not received regular performance reviews and did not have clear objectives. Decision making to support delivery of safe and effective care was undertaken at provider level and local managers were not given authority to ensure appropriate resources were deployed to maintain safe delivery of services. There was a management structure which was top down and directive. Some staff reported concerns that they felt bullied, harassed and discriminated against. We found that staff concerns were raised in respect of these matters but appropriate action had not always been taken.

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. Staff we spoke with and information of concern we received prior to the inspection told us that they felt the provider placed greater emphasis on managing cost and maintaining the service within budget than ensuring staff were supported to undertake their role and deliver the provider's stated goals.

Governance arrangements

There was a leadership structure in place. This placed the majority of decision making powers with senior staff of One Medicare Ltd. It restricted local managers from making decisions in relation to staff allocation and resources required to deliver services. For example, if additional staff were required to deliver services, and meet patient demand, local managers were required to contact the provider's head office or on call manager to obtain approval to bring in additional staff or cover staff absence. When a GP or nurse failed to attend for duty the local manager was not authorised to contact other staff or the locum agency to obtain prompt cover for the absent clinician. This resulted in a delay whilst authority to source cover was obtained and a written purchase order authorised. We found that this had led to the centre being without a GP on site on the morning of Wednesday 1 July and the entire day on Wednesday 29 July.

We saw minutes of the One Medicare Ltd integrated governance committee. These demonstrated that One Medicare Ltd reviewed service information from 11 provider locations. We heard that the outcomes of discussions at this forum were available to staff via desktop files and outcomes of significant event reviews were sometimes disseminated via e-mails. However, staff reported to us that they were not always given feedback on significant event reports they had submitted to this forum. There was a risk that learning from significant events could be missed by staff. This also evidenced that risk to the delivery of timely and safe services to patients from well motivated and supported staff was not being assessed.

Non-clinical staff CQC spoke with described situations where they had been asked to write reports and interpret data for which a summary was required. They had not been fully trained to undertake this role. Two staff members

Are services well-led?

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

described their limited induction programme. One described their induction as being given access to important policies and procedures, being briefed on the health and safety procedures and being taught their job by other staff of a similar grade. Another member of staff said their induction comprised nine hours of being taken through the provider structure and essential health and safety procedures. Staff had not received sufficient training to undertake the core elements of their role.

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 absence of a lead nurse, regional medical director and a newly appointed business manager meant staff felt remote and at risk without senior manager support to carry out their day to day duties. The provider had not responded to staff concerns raised about bullying and discrimination. There was no evidence of a response to the serious concerns raised by a member of staff about inconsistent application of terms and conditions. The provider had also failed to review the reasons for high staff turnover at the service and the effect this had on staff morale among those staff that were still employed.

The provider had received and understood the range of concerns identified by the CCG from their monitoring inspection in May 2015 and subsequent meeting with the provider. The action plan that had been submitted to the CCG had not been completed in a timely manner and omissions were placing patients at risk. For example, PGD's to enable competent nurses to administer and prescribe medicines had not been put in place. The provider had not adequately assessed the risks associated with administration of medicines or taken timely action in response to the CCG concerns about medicines.

The provider held data that identified potential risk to patients of waiting for their assessment and treatment. However, they did not demonstrate that action had been taken to match staffing levels to demand. For example between the hours of 6.30pm and 8pm on weekdays.The computer system used by the provider identified regular peaks in demand and the times of day when patients were kept waiting beyond target waiting times for their assessment. The provider had not acted upon factual information about patient waiting times and had not responded to the risk of patients waiting for their assessment.

Business continuity planning had not been updated to recognise the risks of inappropriate skill mix of staff or the risk when staff failed to attend for duty. Data available to the provider had not been used to recognise the imbalance between staff trained and experienced in dealing with minor illnesses and the demand from patients for this service. Training that would have enhanced skills had not taken place. For example, a seminar on enhancing skills in treating minor illnesses. The provider had recognised, and acknowledged to the CQC, that the demand on the service had been 10% higher in the first year of opening than had been predicted. Following the inspection, the CCG confirmed the activity levels were within the agreed variations of their contract. There was limited evidence to demonstrate the provider had increased sustainable staffing levels to accommodate the additional demand.

The inconsistent feedback from reported significant events was identified when the provider met with the CCG. The provider's action plan stated that a new system was to be implemented on 1 July 2015. The staff we spoke with in August continued to tell us that they did not always receive feedback or learning from significant events. There was a risk that significant events could recur because staff did not receive the earning from previous events. The provider had not recognised their updated system was either not implemented locally or was not effective.

Leadership, openness and transparency

The service was being managed at a local level by a business manager who had been in post since the start of July 2015. It had operated without a Senior Nurse since April 2015 and the regional medical director had not been available since 21 July 2015. Access to local management and leadership had been limited and staff told us that this made it difficult for them to obtain immediate support when they had any issues or problems which required management decisions. However, two members of staff told us that the new business manager was very approachable and they felt able to take any concerns and ideas to them. Staff did not feel the leadership team were engaged with the way they worked. The regional

Are services well-led?

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

operations manager had been acting in the role of head of operations and staff told us that this manager attended the centre for one to two days a week which limited their access to senior management support.

We found that the GPs had received supervision and support from the regional clinical director until March 2015 when the director reduced their commitment to the service to part time. Staff appraisal was inconsistent and we found two of the staff in post for over a year had received appraisal and the other two had not. This limited the opportunity for performance review, goal setting and identification of training needs of staff. We found a member of staff taking administrative responsibilities for tasks they had not been trained to undertake. Another member of staff received an induction that lasted less than two working days.

Staff we spoke with and whistleblowers who contacted the CQC informed us that they found it difficult to report their concerns to senior management because they did not feel their concerns would be listened to or addressed. There was evidence that staff turnover was high. We noted that two of the nurses who joined the service when it first opened had left within a month. Two of the three salaried GPs had resigned and were working their notice periods. Of the eleven of the staff who transferred to the Bracknell Urgent Care Centre in 2014, only three staff were left in post when we inspected in August 2015. Whistle blowers who spoke with us after the inspection confirmed that most of the staff had left because they felt the management of systems and processes were not robust and patient safety was at risk. They also reported that the management and leadership team were not supportive.

We reviewed a number of policies for example, the whistleblowing policy and the recruitment and retention policy. We found that these, along with other management and human resources policies, had been subject to an annual review. Staff were aware there was a whistleblowing policy. However we heard that staff were fearful of reporting concerns to the provider as they felt that they would not be listened to and their concerns would not be investigated fairly and followed up. They also reported being concerned about the fear of reprisal.

We noted that the recruitment and retention policy gave a firm commitment to teamwork where communication of viewpoints, feelings and ideas from staff was encouraged. Staff we spoke with and information received from whistle blowers showed that staff did not feel encouraged to express their feelings and their views. The policy also stated that the provider would not discriminate in their recruitment and retention of staff on any grounds. However, there was no evidence that a significant event which referred to a concern of discrimination in terms and conditions had been investigated and responded to.

The commitment in the recruitment and retention policy to retaining appropriately skilled and qualified staff was not evidenced. Staff turnover was high, there had been recent resignations and the service relied on locum staff to cover over 50% of clinical duties during the month of July. Information of concern we received also referred to decisions on locum recruitment being made by the provider's head office staff without involvement of local managers.

The service seeks and acts on feedback from its patients, the public and staff

The service conducted a quarterly satisfaction survey of 10% of patients who attended the centre. The results of the surveys were reported to the CCG. We were unable to meet with representatives of the small Patient Participation Group that worked with the service because these were unannounced inspections. However, we saw that the service responded to their feedback by adjusting the way the patient information screen was presented.

Management lead through learning and improvement

Nursing staff told us that the provider gave limited, or no, support for them to maintain their clinical professional development through training and mentoring. They were expected to undertake the majority of their continuing professional development (a requirement of continuing professional registration) in their own time and were not supported in this by the provider. There was a record of nurses attending one study afternoon organised by the CCG and records of their mandatory safety training. There were no other records of training opportunities being offered or taken up by the employed nurses.

We saw that GPs were able to access clinical training and attend the local CCG training sessions. They had also received clinical supervision from One Medicare Ltd's regional clinical director up until 21 July 2015. This included mentoring and immediate access to clinical advice. Since 21 July the GPs on site had phone access to the provider's medical directors in Yorkshire and they told

Are services well-led?

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

us this complicated obtaining clinical support and advice. Staff were not supported by a consistent system of appraisal. Clinical supervision for nursing staff was inconsistent with the absence of either a clinical nurse lead or regional medical director. There was not a system in place to ensure all staff received the learning and outcomes from reviews of significant events.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1), (2) (a), (b), (c) and (g)** **Safe Care and treatment** 1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (g) the proper and safe management of medicines; • The provider had not assessed the risks to the safety of patients arising from insufficient staff being on duty or lack of staff with relevant skills and experience. • The provider had not assessed the risks associated with the medicines. Two medicines held in stock were out of date and not fit for purpose. PGD's had not been prepared in accordance with legal requirements and staff were administering medicines without authorisation from a qualified prescriber. The risk to patients of delays in prescribing or authorising medicines had not been assessed because. • The risk to patients of not reviewing radiologist reports of x-rays had not been assessed and a system was not in place to carry out the review of radiologists reports.

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
	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). · The provider had failed to act in a timely manner in response to concerns raised by the CCG. The risks identified in the CCG report of their May 2015 visit had not been addressed. · The provider did not operate a safe system of reporting the outcomes from significant events. · The provider had not assessed, and therefore acted upon, the risks associated with patients not being seen and treated in a timely manner.

This section is primarily information for the provider

Enforcement actions

· Systems in place delayed the provision of a safe service to patients because local managers were unable to source additional staff support at times of peak demand or when staff failed to report for duty.

· Business continuity planning had not been reviewed to recognise the risks from loss of staff.

· The numbers and skill mix of staff had not been adjusted to recognise the risk of increased demand and mix of minor injury to minor illness cases.

· Reports from staff of serious incidents and concerns giving rise to risk had not been reviewed in a timely manner.

· Local managers had not been given autonomy to mitigate identified risks arising from high demand or staff shortages.

· Systems to recognise the risk of high staff turnover and poor staff morale were not operated consistently or effectively.

· The provider had not recognised the risks associated with operation of a management culture of reprisal and fear.