Bracknell Urgent Care Centre

Inspection report

Brants Bridge Clinic
Bracknell
RG12 9BG
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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 location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires Improvement overall. The service was last inspected in October 2018 and rated Good.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services well-led? – Requires Improvement

We carried out an announced (with short notice) comprehensive inspection at Bracknell Urgent Care Centre on 7 March 2022. We carried out this inspection due to concerns we received about the service. We did not include the key lines of enquiry related to caring and responsive services, as there were no risks identified with these key questions. We visited Bracknell Urgent Care Centre and a streaming service based at Wexham Park Hospital, operated and managed by Bracknell Urgent Care Centre.

At this inspection we found:

- Safeguarding processes were in place. Staff had access to policies and referral information.
- Infection control processes were in place and the premises were visibly clean.
- Medicines monitoring processes were not operated in line with national guidance.
- There was insufficient training for clinical staff members caring for children.
- Some clinicians were not provided with formal supervision sessions to monitor their performance. However, staff received formal appraisals.
- Staff received mandatory training and training uptake was monitored.
- The service did not effectively review the quality of care and treatment it provided. There was insufficient clinical audit to ensure appropriate care was always delivered.
- The assessment process in place at the Wexham Park Hospital Streaming service did not ensure that patients who were waiting to see a GP were safe to do so via an appropriately recorded assessment. The service adjusted the design of this service immediately following the inspection to mitigate this risk.
- When 'walk in' patients with minor injuries attended Bracknell Urgent Care Centre, they were not consistently assessed to ensure they would be seen in line with their clinical need and prioritised if needed.
- Staff were dedicated and passionate about the care they provided. Staff reported a positive supportive culture between colleagues and felt well supported by the local leadership.
- Governance structures were not always operated as intended which had resulted in risks not being identified and mitigated.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Effective governance systems must be implemented to ensure appropriate monitoring of quality and risk.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a Specialist Advisor in urgent primary care and a member of the CQC medicines team.

Background to Bracknell Urgent Care Centre

Bracknell Urgent Care Centre is located in a purpose built 'Healthspace' near the centre of Bracknell and provides urgent care services to the local population and the surrounding areas. The service is commissioned by Frimley Clinical Commissioning Group to provide assessment, care and treatment for both minor injury and minor illnesses. Only a small number of patients are seen as 'walk-ins', the majority are referred from NHS pathways such as the NHS 111 service or by their own GP practice.

Bracknell Urgent Care Centre also manages and delivers a GP streaming service at Wexham Park Hospital in Slough. The streaming service provides assessment to patients attending the hospital's A&E department, streaming those deemed appropriate to be cared for by trained primary care clinicians, to GPs based onsite. All other patients remain A&E department patients. The patients allocated to the streaming service wait and are seen in the A&E department.

The service is one of 11 registered services managed and operated by One Medicare Ltd (the provider). These include urgent care centres, GP practices, and walk-in services. The provider's head office and operations centre is based near Otley in West Yorkshire.

On the day of our inspection, the day-to-day operation of the service was managed by a clinical service manager, who is also the registered manager for the centre. There is also a GP clinical lead in post and a deputy clinical service manager.

Bracknell Urgent Care Centre is registered with the CQC to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

All the regulated activities are offered or managed from:

Brants Bridge
Bracknell
RG12 9RT

The service is open from 8am – 8pm, seven days a week.

Requires Improvement

Are services safe?

We rated the service as Requires Improvement for providing safe services. The service was not ensuring that all risks related were identified and mitigated to prevent potential harm to people who use the service.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse.

- The service worked with other agencies to support patients and protect them from neglect and abuse. There were processes in place to ensure staff had access to information and could act if required, to protect patients from abuse or harm.
- Staff were overdue their level three adult safeguarding training, due to a lack of course availability. Interim training was being provided in-house via a presentation and a course was booked for the staff requiring this training in October 2022. All staff required to have child safeguarding level three training were up to date with this training according to the service's training log.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). References and vaccination records were also requested for new staff.
- Agency staff who required background checks at the same standard as permanent staff had these undertaken by the agency who supplied them. The provider obtained evidence to confirm the checks had been made.
- Staff who acted as chaperones were trained for the role and had received a DBS check. There were signs to make patients aware of the availability of chaperones.
- There was an effective system to manage infection prevention and control. There were systems for safely managing healthcare waste, at both sites.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were not always adequate.

- Patients attending the centre as 'walk-ins' were not assessed to ensure they were safe to wait and that they were prioritised on risk.
- There was a lack of appropriate assessment for all patients attending the Wexham Park Hospital streaming service (designed to identify patients who could be seen by a primary care clinician). We identified patients waiting up to two hours without an appropriate assessment documented of their clinical needs. The service immediately altered its system for assessing patients at the streaming service to mitigate the risks we identified.
- There were arrangements for planning and monitoring the number and mix of staff. There were contingency plans and tools in place for monitoring and dealing with surges in demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. However, there was no means for some clinicians to print patient information leaflets.
- The provider ensured that premises were safe and that their equipment was maintained according to manufacturers' instructions. However, at the Bracknell site clinicians also used their personal clinical assessment equipment and there was no monitoring on the part of the provider to ensure this equipment was calibrated and safe to use. The premises at Wexham Park Hospital were managed by the hospital's facilities staff.

Requires Improvement

Are services safe?

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- There were site specific protocols at the Wexham Park Hospital streaming service and Bracknell Urgent Care Centre, which were available for staff.

Appropriate and safe use of medicines

The service did not have reliable systems for appropriate and safe handling of medicines.

- We identified a large surplus stock of blank paper prescription forms (approximately 18,000) at the Bracknell site. The provider took action to reduce this backlog after the inspection visit.
- At the Bracknell site, the printers used for printing prescriptions were located in each consultation room. The clinicians responsible for prescribing were on occasion required to leave the room during the consultation; for example if they needed to retrieve medicines, but the printers were not lockable. This is not in line with national guidance and posed the risk of misuse.
- During the inspection we found there were duplicate processes for checking emergency medicines and equipment and it was not clear if these were being followed consistently. Following the inspection we were provided with a daily huddle sheet from March 2022 which indicated that the emergency medicines and equipment were all checked regularly in line with the huddle check sheet.
- At the Wexham Park Hospital streaming service, the A&E department had emergency medicines and equipment available should they be required for any patient.
- Patient Group Directives (PGDs provide authorisation for staff to provide some specific medicines who are not qualified prescribers) were in place to ensure appropriate authorisation of medicines for non-prescribing clinical staff. We found they were up to date and listed the staff who provided medicines under their authorisation.

Track record on safety

There was a lack of governance oversight which meant that risks were not always being adequately identified, assessed and mitigated.

- There was a system for receiving safety alerts. However, the system for obtaining Medicines and Healthcare Products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts did not ensure that appropriate actions were noted on the log used to record them. Therefore, the information required by staff may not have been available when required and there was no indication that any actions taken had been monitored to ensure they were effective.

Lessons learned and improvements made

The service recorded and reviewed incidents.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. However, the incident log did not contain any reference to concerns related to clinical learning events, incidents of identified risk or near misses. There were six incidents reported since September 2021. These were related to a temporary loss of IT function or local services, such as X-ray department, and one regarding inappropriate behaviour of a patient.

Requires Improvement

Are services safe?

- The service used team meetings to communicate learning from incidents. However, these were not taking place monthly as intended. The clinical service manager informed us this was due to the additional pressures imposed by the wave of COVID 19 infections during the recent winter months.

Requires Improvement

Are services effective?

We rated the service as Requires Improvement for providing effective services. We found there was not always appropriate assessment of patients or monitoring of care to ensure effective services were always provided.

Effective needs assessment, care and treatment

Patients were not always assessed appropriately or in line with national guidance.

- Staff had access to clinical guidance they could refer to as required. At the Bracknell site, this was in both electronic and in paper format in communal areas.
- There were a small number of patients who attended the Bracknell site as 'walk-ins' for minor injury treatment with no prior triage or assessment at another service. We were informed these patients would wait to see the next available clinician. There was no process to ensure these patients received an assessment to ensure they received an appropriate assessment of their safety to wait for care or that they could be cared for within the service.
- Following initial findings of the Wexham Park Hospital streaming service during the inspection, the service amended their protocols for assessing patients to deem whether they could wait to be seen by a GP. We saw records of these assessments in the week following the inspection visit. The records identified improvements to the recording of the assessments.
- We saw no evidence of discrimination when making care and treatment decisions.
- Technology and equipment were used to improve treatment and to support patients' independence.
- The waiting area at the Bracknell location was in sight of the reception desk which provided visual oversight of patients, should they rapidly deteriorate and require urgent medical attention.

Monitoring care and treatment

Appropriate assurances were not always obtained regarding the quality of care through audit and monitoring.

- The provider reviewed the effectiveness of services through the use of key performance indicators (KPIs) and quality improvement visits as part of the providers quality assurance framework. This included reviews of patient journey and patient numbers attending the service. However, there was no assessment of wait times for patients who attended as walk-ins to monitor the safety of the service in this regard.
- During the site visit to Bracknell Urgent Care Centre we requested the clinical audits undertaken to assess the quality and safety of care provided by clinicians. We were provided with quarterly audits for each clinician which contained a review of five consultation notes and a review of the appropriateness of 20 instances of antibiotic prescribing. There were no other clinical audits undertaken. The clinical service manager informed us that formal supervision sessions regarding clinicians' care and treatment were not undertaken routinely, only informally when requested. There was not sufficient auditing and monitoring of performance to assure the provider of quality and safety in respect clinicians' care provision.

Effective staffing

Staff did not always have the skills, knowledge and experience to carry out their roles.

- The provider had an induction programme for all newly appointed staff.
- We found that staff did not have regular formal clinical supervision sessions. There was a lack of ongoing competency assessment for nurses and other clinicians (other than GPs) working at the service. We were told staff could access support from the clinical leads or GP when required.

Requires Improvement

Are services effective?

- We asked both the service GP lead and the clinical service manager at Bracknell Urgent Care Centre what training clinicians other than GPs had in order to ensure their competencies in caring for children. The staff members confirmed that the clinicians had 'spot the sick child' training. There was no other formal training provided to ensure staff could appropriately assess the care needs of children assessing the service or ensure that they would refer the child to an onsite GP if they identified an alternative assessment was required by a more qualified clinician.
- There was a training log in place which was monitored by the provider. Staff were prompted to undertake core training where required. We saw staff training was up to date in nearly all core training areas and that it was monitored appropriately.
- Staff received an annual appraisal where they could discuss their own development needs and suggestions.

Co-ordinating care and treatment

Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

- The service had formalised systems with the NHS 111 service and local GP practices, with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

The service identified patients who may be in need of extra support, such as carers or people who required local community services. Information on how to access relevant services was available to staff and could be provided to patients.

- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this, although some clinicians did not have the ability to print patient information leaflets and therefore lacked the ability to provide patients with information in a format they could take away and readily access.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service had systems to obtain consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.
- Staff received training on the Gillick Competency (regarding obtaining consent from children under 16 years old).
- Staff had guidance available on the Mental Capacity Act (2005).

Requires Improvement

Are services well-led?

We rated the service as Requires Improvement for providing well led services. There were gaps in governance and some areas where quality assurance processes were lacking. Risks to patients were not always identified proactively due to a lack of appropriate monitoring of care.

Leadership capacity and capability

Leaders did not have the capacity to effectively assess the quality of the services provided and ensure improvements were implemented where required.

- There had been pressure on the service due to the COIVD-19 pandemic. Staff explained that due to the increase in infections during December 2021 and January 2022 no clinical meetings had taken place. Staff also reported that daily huddles did not always take place. This had resulted in a lack of communication regarding operations. The service had held recent clinical meetings and was re-introducing daily huddles.
- There was a lack of clear communication in regards to some areas where actions may be required for safety assurance purposes. For example, the medicine (MHRA and CAS) alerts log was not updated to ensure appropriate action was in place as a result of alerts.
- Staff felt the clinical service manager and GP lead were approachable and supportive. They consistently stated they were able to approach them and ask questions if needed. Both members of staff were also providing clinical care and their time was divided between their leadership roles and clinicians.

Vision and strategy

The service had a vision and strategy. However, the provider's strategy did not always reflect relevant national guidance in order to ensure appropriate services were delivered.

- Both the Bracknell Urgent Care Centre and Wexham Park Hospital streaming service were designed in collaboration with local stakeholders including the Frimley Clinical Commissioning Group (CCG). There was a coordinated approach to ensuring patient pathways and referral processes worked appropriately and were in line with local requirements.
- The provider did not always ensure their own responsibilities were met in terms of delivering safe services in how they planned and designed them. For example, prescription security protocols were not in line with national guidelines.
- The service did not independently identify the quality concerns CQC identified at the streaming service. However, the service took immediate action once this concern was highlighted.

Culture

The service had a culture of supporting and listening to staff. However, there was a lack of proactive engagement with staff relating to formal supervision.

- Staff told us they felt supported working at the service. They informed us they could ask for additional training, development or support at their appraisals.
- Staff reported and were passionate about delivering a patient-centred service and when they spoke about the care they provided.
- There was a lack of formal support processes such as formal supervision for staff who required appropriate checks as part of assurances their work was appropriate.
- Staff told us they were able to raise concerns and were encouraged to do so.

Governance arrangements

Requires Improvement

Are services well-led?

Clear responsibilities, roles and systems of accountability to support good governance and management were not in place at the time of our inspection.

- Monitoring tools such as the clinical audit programme were not adequate to provide assurances that clinical performance was appropriate and safe. The lack of supervision of clinical staff led to a risk that those staff working autonomously, other than GPs, were doing so without assurances their care was effective and safe.
- The provider was not ensuring that governance systems were being operated appropriately by the local leadership team. This led to risks associated with not monitoring equipment and medicines and poor monitoring of clinical care.
- The clinical service manager was responsible for overseeing both the streaming service at Wexham Park Hospital and the Urgent Care Centre in Bracknell, as well as providing clinical care. There was a lack of appropriate monitoring regarding the new streaming service, which had been operating for approximately five weeks, to ensure its effectiveness and safety following implementation.
- The provider had not established an appropriate assessment framework to ensure that all patients were triaged appropriately to make sure they received access to care in an organised and timely manner.

Managing risks, issues and performance

There were not clear and effective processes for managing risks, issues and performance.

- Staff understood their duty to raise concerns and report incidents and near misses. However, the service's incident log did not contain any reference to concerns related to clinical learning events, incidents of identified risk or near misses. There were six incidents reported since September 2021. These were related to a temporary loss of IT function or local services, such as X-ray department, and one regarding inappropriate behaviour of a patient.
- There was poor monitoring and identification of risk due to poor operation of monitoring processes. For example, patients who attended with no prior assessment of their needs were not provided with a triage to assess their suitability to wait.

Appropriate and accurate information

Information was stored and gathered in line with data protection requirements.

- The service monitored its patient numbers and identified where these patients had been referred from. This helped identify staffing requirements and rotas. However, there was a lack of analysis to monitor wait times for patients.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service sought feedback and included patients, the public, staff and external partners in the operation of the service.

- The service used the Friends and Family test to gain feedback from patients. This suggested high satisfaction rates with the service. For example, of the 41 patients who provided feedback in January 2022, 40 patients rated their experience of the service as very good and one patient rated it as good.
- The service engaged with local stakeholders such as the CCG and other healthcare services.

Continuous improvement and innovation

There were limited systems and processes for learning, continuous improvement and innovation

Requires Improvement

Are services well-led?

- There was minimal identification of where quality improvements were required.
- The service made use of internal and external reviews of incidents and complaints. However, learning was not being effectively shared and used to make improvements.

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 17 HSCA (RA) Regulations 2014 Good governance The provider was failing to assess, monitor and improve the quality and safety of the services. There were not appropriate systems to 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 activities. This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.