Brambles

Inspection report

Grenwich Ave
Geary Drive
Brentwood
CM15 9DY
Tel: Contact is via patient's usual Brentwood GP practice

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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 caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This service is rated as Requires improvement **overall.**

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive at Brambles extended hours service as part of our inspection programme.

GP extended hours access service is provided by Accountable Care Enterprise Ltd (ACE) which is owned by the eight GP practices in Brentwood. Each of the practices has a representative on the board, with a role within the governance structure of the organisation.

At the time of our inspection the provider's registered manager had just left and they were in the process of completing forms for the new registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We received feedback about the service from 16 people. People told us that staff were caring, helpful and professional. They felt they were listened to and treated with dignity and respect. People were positive about the service experienced from both GPs and nursing staff. They told us the service was efficient and ran to time.

Our key findings were:

- There was a safeguarding system in place.
- Records were kept relating to some identity checks, qualifications and training of staff, however this did not include the immunisation status of all staff and identify checks for some staff.
- There were systems in place for the management of medicines and prescription stationery.
- Emergency medicines and equipment were kept and monitored.
- There were arrangements in place for risk assessment and maintenance of facilities and equipment. Where this had been completed by an external provider they did not always have a copy of the assessment and outcome. This was remedied following our inspection.
- Although staff had access to clinicians and managers whilst working, they had received no appraisals, or had their work reviewed to check they were working within their competencies.
- There was no evidence of written instructions for the administration of B12 treatments for named patients, for a sample of patients viewed.
- Care and treatment was provided in line with best practice guidelines.
- There were policies and procedures in place for staff. For one clinical activity, there was no protocol in place to promote consistency of care.
- The practice had completed some audits. They used these and other information to review and improve the service provided.
- Patient's felt treated with dignity and respect. They were positive about the attitude of staff.
- There was a system in place for complaints, but there was no signposting for patients on how to access this.
- Staff told us they felt supported by managers and GPs.
- There was a clear leadership and governance structure.

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

- Ensure care and treatment is provided in a safe way to patients

(Please see the specific details on action required at the end of this report).

The areas where the provider **should** make improvements are:

- Implement a protocol for wound dressings.
- Implement a system for periodically checking the registration status of staff.
- Implement a system so that where other providers have completed risk assessments, routine maintenance or other actions, the service have copies of these.
- Review how they identify to patients how to access the complaints system, when not at service location.

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 and included a GP Specialist Advisor.

Background to Brambles

This service is provided by Accountable Care Enterprise Ltd (ACE) at the Brambles Surgery, Geary Drive in Brentwood. The service provides an extended hours GP service to patients registered at all Brentwood practices. Appointments are booked through the patient's usual GP practice. The service is provided from 6.30pm to 8.30pm Monday to Friday, 8am to 2pm on Saturdays and Sundays, 10am to 2pm on Bank Holidays. The premises are also used as a branch of a local practice prior to 6.30pm on some week days, this service is separate to the extended hours service we inspected.

How we inspected this service

Prior to this inspection, we spoke with stakeholders and reviewed a range of information that we hold about the service.

During the inspection we:

- Reviewed systems and documents relating to the governance of the service.
- Explored how clinical decisions were made and how these were relayed to the patients usual GP.
- Observed staff interactions with patients
- Talked to people using the service and their relatives
- Spoke with a range of staff.
- Reviewed CQC comment cards which included feedback from patients about their experiences of the service.

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

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires improvement

Are services safe?

We rated safe as Requires improvement because:

Systems relating to staff immunisation and ensuring staff were working within their competency level required strengthening. The service had systems for appropriate and safe handling of medicines. However, the system in place for the administering of patient specific medicines was not effective.

We identified a safety concern that was rectified soon after our inspection. The likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor.

(See full details of the action we asked the provider to take in the Requirement Notices at the end of this report).

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse, but these required strengthening.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The staff working at the service were known to the managers, as they had worked at one or more of the eight practices at some point or were still currently employed by them. There was evidence of some staff checks at the time of recruitment, including registration checks. The service did not have evidence of immunisation status for some staff. Some checks such as character and conduct, were not documented but had been made through working existing or previous relationships with those staff, and we were satisfied that these staff had been employed safely. 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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was a system to manage infection prevention and control. Legionella checks were completed by the property landlord, and any necessary actions to mitigate the risk were completed by the practice who utilised the premises during the day. Until recently, the service had relied upon the in-hours service provider to complete infection control audits. They did not have a copy of this audit on the day of inspection, however obtained a copy after our inspection, which they sent us. The service had made the decision, prior to our inspection, to complete their own infection control audits, this was scheduled to be completed in January 2020.
- The provider had arrangements in place with the practice who utilised the premises during the day, to ensure that facilities and equipment were safe. They did not have evidence that risks and issues, identified during assessments and routine maintenance, had been dealt with by the in-hours service provider. After our inspection, they obtained copies of completed action plans relating to this, which we saw confirmed all required actions had been taken.
- They had a system to ensure that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was a comprehensive staff handbook which outlined key policies and processes.

Requires improvement

Are services safe?

- 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.
- There was no system in place to review whether staff were performing within the limits of their competency.
- There were medicines and equipment to deal with medical emergencies, which were stored appropriately and checked regularly. Some items recommended in national guidance were not kept and there was not an appropriate risk assessment to inform this decision. However, the missing items were purchased immediately after our inspection and evidence of this provided.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place. If staff were unable to evidence their indemnity arrangements they would not be offered sessions, until evidence was provided.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service had systems for appropriate and safe handling of medicines. Although systems in place for the administering of patient specific medicines required strengthening.

- The systems and arrangements for managing medicines, including emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- The service had copies of the local prescribing guidelines available to staff.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance, with the exception of the administration of B12 treatments. For these, there were no written instructions, known as patient specific directions (PSD), for a sample of patient records viewed. PSDs are instructions from a qualified and registered prescriber which include the dose, route and frequency of a medicine to enable these medicines to be correctly administered. Following our inspection, the provider sent us a copy of a template PSD, which they planned to use from now on.
- Processes were in place for checking medicines and staff kept accurate records of medicines.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, following an incident with a written prescription, the practice took appropriate action to involve other agencies and reviewed their systems and processes around how prescriptions were generated. Minutes of meetings confirmed discussion of this incident.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

Requires improvement

Are services safe?

- There were systems in place to give affected people reasonable support, truthful information and a verbal and written apology.
- The service have systems in place to act on and learn from external safety events as well as patient and medicine safety alerts. The service had a mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. If patients were seen at the service, who were likely to be affected by a safety alert, the service would make the patient's usual GP practice aware of the need to review this.

Requires improvement

Are services effective?

We rated effective as Requires improvement because:

Staff did not receive regular appraisal to determine their training and development needs.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Although part of the nurses' clinical work was wound care, we found there was no protocol for wound dressing to promote consistent standards of care.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing. Any ongoing needs were relayed back to the patient's usual GP practice.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

The service used information about care and treatment to make improvements. The service made improvements through the use of audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, monthly clinical notes audits were conducted. There was evidence that where clinical notes were lacking this was relayed back to the individual clinician to make improvements.

The service also had a number of performance targets with their commissioners. They sent regular information relating to performance against, for example, operation standards, did not attend rates (DNA) and complaint response times. We viewed records of recent KPIs which demonstrated compliance with all key performance indicators aside from a DNA rate that was higher than desirable.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had set of mandatory training for all staff.
- Registration Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation
- Up to date records of skills, qualifications and training were maintained.
- Staff whose role included immunisation and reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date.
- However, staff had not received any formal appraisal by the service since the service started. The service told us that they were aware of the lack of appraisals and had plans to complete these going forward.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. Clinical staff communicated with the patient's usual GP service via a system of notes on the patient's online record.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. When their appointment at the service was booked by their usual GP practice, the patient was requested to consent to their practice sharing their information with the service. If a patient declined, consent to information sharing was requested at two further points. If a patient declined information sharing from the practice, then the service would not be able to access the patient's medical and medicines history. Safe

treatment at the service might not be possible without this view, therefore depending on what the reason for the appointment was, a patient may be redirected back to their usual GP practice for care and treatment.

- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, the service used the same system as the GP practice, so the patient's medical record was updated automatically. If actions were required by the patient's usual GP practice, then the service would use a system of tasks to alert the GP practice of actions required.
- Care and treatment for patients in vulnerable circumstances was usually completed by the patient's usual GP. Vulnerable patients were unlikely to be triaged as suitable for an appointment with the service as continuity of care was deemed to be preferable. However, if vulnerable patients needed to be seen there were systems in place to ensure that care was coordinated with other services.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate, highlighted to their usual GP practice for additional support. For example, patients identified as having high blood pressure on health checks.
- 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 obtained consent to care and treatment in line with legislation and guidance .

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

Patients were positive about how they were treated by staff. They felt involved in decisions about their care and treatment. The service respected patients' privacy and dignity.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language.
- Patients told us through comment cards and in person, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Patients with more complex needs were unlikely to be seen at this service. If extended hours were required they would be seen at their usual GP practice within that practices extended hours provision. This was simply as the patient's usual practice would be better placed to meet their needs and to ensure continuity of care.
- Staff communicated with people in a way that they could understand. Where information sharing consent was in place, the service had access to any information on reasonable adjustments required via the patient's online record.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- If patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private area to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Patients were able to access care and treatment according to their preferences. The service reviewed feedback from practices and their patients and used this to improve the service for patients. There was a system in place for complaints, however this was not clearly advertised.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs. For example, when the service was initially set up, each of the eight GP practices was allocated one slot a day at a specified time. Feedback from patients and GP practices was that patients preferred more flexibility on the times of appointments. In response to this, the service changed the system so that practices still had one slot but could book into any available time.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. However, most patient's in vulnerable circumstances would be seen within their usual GP practice, during the GPs extended hours, if this was preferable. This ensured continuity of care for the most vulnerable groups.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Appointments were offered to patients and booked by their usual GP.
- Referrals and transfers to other services were undertaken in a timely way. The service had a system for monitoring two-week wait cancer referrals. Where follow up was required from the patient's usual GP, this was completed via the use of notes on the patient's online record.

Listening and learning from concerns and complaints

The service had systems in place for complaints handling.

- There was a system in place for complaints, with signs displayed at the location during the hours of service provision. However, literature relating to the service on the eight practices websites did not refer to how to complain about the service offered. Patient's told us that they would complain via their usual GP practice if required.
- The service had complaint policy and procedures in place. The service received feedback from patients via the practices which it acted as a result to improve the quality of care. The practice had only received one complaint, however this related to the road condition adjacent to the service and was redirected to the appropriate local government department.

Are services well-led?

We rated well-led as Good because:

There was a clear leadership structure in place. Staff felt supported. The service regularly communicated with stakeholders to review and adjust how the service was delivered to ensure that it met the needs and expectations of patients. There were some areas of the service that required development to ensure the safety of patients and staff. The service was already aware of some of these prior to our inspection and had an action plan in place. For other issues not previously identified by managers, the service reacted swiftly following our inspection to either remedy the situation or put actions in place to resolve these for the future.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt supported.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Staff had not received a regular annual appraisal in the last year, however had access to support from managers and GPs. Audit reviewed the ongoing performance of staff and any issues were raised with staff at that time. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team.
- There was a strong emphasis on the safety and well-being of all staff.
- The service promoted equality and diversity.
- There were positive relationships between staff.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. They reviewed this on an ongoing basis and had identified prior to our inspection areas that needed improvement. These areas aligned with our inspection findings.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and when they were received would have oversight of complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- 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 involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. For example, the allocation of appointment slots had been changed in response to patient feedback.
- We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were evidence of some systems and processes for learning and continuous improvement.

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents. Learning was shared and used to make improvements.
- Clinical staff performance was monitored through their clinical records. However, there was limited evidence that staff were encouraged to take time out to review individual and team objectives, processes and performance.
- Due to the nature of the service, there was limited evidence of innovation. The service did have future plans to expand the remit of the service provided.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • There were no records of immunisation status for some staff, including administrative. • There were gaps within proof of identity checks for new staff. • There was no system in place to appraise staff or review that they were working within their competencies. • There was no evidence of patient specific directions, being attached to the electronic record, for the sample of patient records viewed.