Enderby Medical Centre

Quality Report

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Date of inspection visit: 23 September 2016
Date of publication: 21/04/2017

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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 11 May 2016. Breaches of legal requirements were found in relation to governance arrangements within the practice. We issued the practice with two warning notices requiring them to achieve compliance with the regulations set out in those warning notices by 1 July 2016. We undertook this focused inspection on 23 September 2016 to check that they now met the legal requirements. This report only covers our findings in relation to those requirements.

At this inspection we found that the requirements of the two warning notices had been met. Our key findings across the areas we inspected for this focused inspection were as follows:

Summary of findings

- The practice had made considerable improvements since our last inspection. We saw there was now an effective system in place for reporting, recording and acting on significant events.
- Complaints were logged but the system required further development to evidence that complaints were fully investigated, learning identified and actions implemented.
- There was now an effective system for disseminating and acting on safety alerts.
- The practice had reviewed the arrangements for triaging and seeing patients with minor illness. The necessary training had been undertaken to provide this safely.
- There were arrangements in place for assessing and monitoring risks and the quality of the service provision.
- Policies were available which had been reviewed and gave staff guidance to carry out their roles in a safe and effective manner and reflected the requirements of the practice.
- A comprehensive system had been introduced to ensure national guidance was disseminated, discussed and implemented.
- Blank prescriptions were handled in accordance with national guidance.
- Some Patient Group Directions (PGDs) were not signed appropriately.
- There was a clear leadership structure and staff felt well supported.

The areas where the provider should make improvements are:

- Ensure Patient Group Directives are appropriately signed.
- Ensure complaints are fully investigated, learning identified and actions implemented.

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?

- There was an effective system in place for reporting, recording and acting on significant events and complaints which required embedding further.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- Risks to patients who used services were assessed and well managed.
- Blank prescriptions were handled in accordance with national guidance.
- Some Patient Group Directions (PGDs) were not signed appropriately.
- There was now an effective system for disseminating and acting on safety alerts.

The practice had reviewed the arrangements for triaging and seeing patients with minor illness. The necessary training had been undertaken to provide this safely

Are services well-led?

- Since our inspection in May 2016 we found that the new management structure was being embedded, staff were taking on new responsibilities and working effectively together. There was a clear leadership structure and staff felt well supported.
- The practice had updated a number of policies and procedures to govern activity which had all been reviewed.
- A schedule of regular staff meetings had been scheduled.
- A comprehensive system had been introduced to ensure national guidance was disseminated, discussed and implemented.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Ensure Patient Group Directives are appropriately signed.
- Ensure complaints are fully investigated, learning identified and actions implemented.

Enderby Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Enderby Medical Centre

Enderby Medical Centre is a GP practice which provides a range of primary medical services to around 6,080 patients from a surgery in Enderby, a suburb on the outskirts of the city of Leicester. The practice has more patients under the age of 50 years than the national average and less patients 50 years or over than the national average.

The service is provided by one full time and one part time female GP partners, two part time male GP partners providing a total of 22 sessions per week. There was also a nurse practitioner who provided a further eight sessions per week. The nursing team is completed by two practice nurses and a healthcare assistant. They are supported by a part-time locum pharmacist, a practice manager, an assistant practice manager and a team of reception and administration staff.

The practice's services are commissioned by East Leicestershire and Rutland Clinical Commissioning Group (CCG). The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Local community health teams support the GPs in provision of maternity and health visitor services.

The practice had a website which provides some information about the healthcare services provided by the practice.

The provider has one location registered with the Care Quality Commission which we inspected on 11 May 2016 which is Enderby Medical Centre, Shortridge Lane, Enderby, Leicestershire. LE19 4LY.

The practice is open between 8.00am and 6.30pm Monday to Friday but with extended hours on Wednesday from 7.15am to 7.30pm. Appointments are available from 08.30am to 11.00am in the morning and from 3.00pm to 6.15pm on a daily basis. On Wednesdays the first appointment was 7.15am and the last appointment 7.00pm. The practice offers telephone consultations and home visits are also available on the day of request.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided to Leicester City, Leicestershire and Rutland by Derbyshire Health United Limited. There were arrangements in place for services to be provided when the practice is closed and these are displayed on their practice website.

Why we carried out this inspection

On 11 May 2016 we had carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the

Detailed findings

overall quality of the service, and to provide a rating for the service under the Care Act 2014. Breaches of legal requirements were found and two warning notices were issued in relation to

governance arrangements. As a result we undertook a focused inspection on 23 September 2016 to follow up on whether action had been taken to address the breaches.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice. We carried out this announced visit on 23 September 2016. During our visit we:

- Spoke with a range of staff including; GP partners, the practice manager and administrative staff.
- Reviewed documentation relating to the practice including policies and procedures.

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

Are services safe?

Our findings

Safe track record and learning

At our inspection in May 2016 we found that the practice did not have processes in place to prioritise safety, identify risks and improve patient safety such as a process to learn from significant events or complaints.

At our inspection in September 2016 we found that a new and effective system for dealing with significant events had been introduced. The system was comprehensive, staff had received training regarding significant events and there was a specific template used for recording. A detailed log was kept of significant events, with each incident numbered, categorised and details kept of review dates, actions and where and when events had been discussed. There was a meeting planned to discuss significant events as well as an annual review meeting of significant events and we saw that they had begun being discussed at clinical meetings. This system required embedding to ensure its ongoing effectiveness.

At our inspection in May 2016 we found the system for dealing with safety alerts was not effective as there was no evidence available of any actions taken as a result of any alerts received. At our inspections in September 2016 we found there was now an effective system in place. The practice kept a log of all alerts, which included when they were received, responsibility within the practice for dealing with the alert and evidence of dissemination and actions.

Overview of safety systems and processes

- At our inspection in May 2016 we found that not all staff who acted as chaperones had received training for the role. At our inspections in September 2016 we saw that the chaperone policy had been reviewed in August 2016 and updated to include all staff members who carried out chaperone duties. These staff members had now completed chaperone training.

  A notice in the waiting room advised patients that chaperones were available if required. Staff who acted as chaperones had all received a Disclosure and Barring Service (DBS) check. (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).

- At our inspection in May 2016 we found that there were no safety data sheets or control of substances hazardous to health (COSHH) risk assessments available for cleaning products used by the practice. At our inspection in September 2016 we saw that room checks had been carried out to identify all products in use in the practice. Following this a comprehensive file had been created which contained a list of all products in use in the practice with review dates, risk assessments and safety data sheets for each product. There was now a COSHH policy which was dated September 2016 to provide guidance.

- At our inspection in May 2016 we found that there was no system in place to monitor the movement of prescription pads through the practice. At our inspection in September 2016 we saw that an effective system had been implemented to track the movement of prescription pads in addition to the system that had already been in place to track blank prescription forms for use in printers. Both prescription pads and forms were securely stored.

- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. At our inspection in May 2016 we found that one of these was out of date and none had been signed by an authorising manager. At our inspection in September 2016 we found that one of the PGDs was still out of date although some of the PGDs had now been authorised.

- At our inspection in May 2016 we found that that appropriate recruitment checks had not always been undertaken prior to employment and the recruitment process had not been operated effectively to ensure staff had the qualifications and competence for the work performed by them. At our inspection in September 2016 we found that the recruitment policy had been reviewed in May 2016 and DBS checks had been undertaken for all staff.

- At our inspection in May 2016 we found that the practice had recently introduced a triage system. We found that the nurse practitioner who was undertaking the telephone triage had not undertaken specific training in telephone triage or specific training to enable them to

Are services safe?

see children with minor illness. At our inspection in September 2016 we found that the nurse practitioner had now undertaken the appropriate training and there was a triage policy in place.

Monitoring risks to patients

In May 2016 we found that not all risks to patients were assessed and well managed. At this inspection we found:

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy dated May 2016 and an associated risk assessment to monitor the safety of the premises. We saw that an action plan had been created as a result of the risk assessment and had been updated on a monthly basis as to progress. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- At our inspection in May 2016 we found issues with fire safety such as lack of fire drills and fire safety training. At this inspection we saw that the fire safety policy had been reviewed in September 2016 and fire drills had been carried out and documented. Fire safety training had been undertaken and there were identified fire marshals. Checks of fire equipment were also being carried out regularly.
- The practice had other risk assessments in place to monitor safety of the premises. At the time of our inspection in May 2016 a legionella risk assessment had been undertaken but the report was not available. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. At this inspection we saw the risk assessment and that recommended actions had been implemented in order to mitigate the risk, including monthly monitoring of water temperatures.

Arrangements to deal with emergencies and major incidents

- At our inspection in May 2016 we found that the practice did not have a defibrillator available on the premises and had not risk assessed the need for a defibrillator. At this inspection we saw that the practice had purchased a defibrillator and staff had received training in its use.

Are services well-led?

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

Our findings

Vision and strategy

The practice told us they had a clear vision to deliver high quality care in an integrated manner and with a focus on continuity.

Staff we spoke with shared these values and it was apparent from talking to staff and the feedback from patients that they still demonstrated an ethos of putting patients first. Since our inspection in May 2016, the GP partners and practice management team had implemented a number of plans they had spoken about at the initial inspection were starting to embed them.

The restructuring of the management team which had been recently introduced at our inspection in May 2016 was now further established.

Governance arrangements

At our inspection in May 2016 we found that the practice did not have an overarching governance framework and systems and processes in place to support the delivery of their strategy. At this inspection we found :

- A number of practice specific policies were implemented and were available to all staff. They had been reviewed and were up to date and contained the correct information to provide guidance to staff. These now included the previously absent significant event policy and cold chain policy.
- The practice now had an effective system in place to identify, record and manage risk with specific risks now having been assessed in addition to general risks.
- There were now systems and processes in place for the effective reporting, recording and monitoring of significant events and incidents and a system in place to log complaints. These systems still needed to be embedded.We found that it was still not clear that complaints had been fully investigated, learning identified and actions implemented. However we saw that a complaints meeting was planned to discuss complaints received and actions.
- The system to ensure that the patient group directives (PGD's) were signed by an authorising manager or were up to date was still not effective as somePGDs were still not signed appropriately.

Leadership and culture

At our inspection in May 2016 we found a lack of leadership and governance relating to the overall management of the service and at the time the practice was unable to demonstrate strong leadership in respect of safety. At this inspection we found that the leadership had strengthened considerably and areas of responsibility had been identified. The practice had reviewed the arrangements for triaging and seeing patients with minor illness. The necessary training had been undertaken to provide this safely.

At our inspection in May 2016 we found that despite a variety of meetings being held, some of the meetings were informal and minutes were limited. At this inspection we found that there was a comprehensive schedule of meetings planned.

At our inspection in May 2016 we found that the practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. However at that inspection we also found that there was not an effective system to keep all clinical staff up to date.

At this inspection in September 2016 we saw minutes of meetings that reflected that going forward one of the GP partners would be taking the lead for ensuring staff were kept up to date.