Clay Cross Medical Centre

Quality Report

Bridge Street
Clay Cross
Chesterfield
S45 9NG
Tel: 01246 862237
Website: www.claycrosssurgery.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The practice had previously been inspected in September 2015 and found to be requires improvement for providing safe, effective and well-led services and good for providing caring and responsive services. We undertook a further comprehensive inspection in November 2016 to ensure the provider had made improvements.

In September 2015, the provider was found to be in breach of Regulation 19 of the Health and Social Care Act 2008 due to concerns regarding the absence of background checks undertaken for staff acting as chaperones. Following this inspection, the provider was issued with a requirement notice and provided an action plan to the CQC.

We carried out an announced comprehensive inspection at Clay Cross Medical Centre on 2 November 2016 and 10 November 2016. Overall the practice is rated as inadequate.

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

- Systems for reporting and recording significant events were not being operated effectively. Incidents and significant events were not always documented, investigated and discussed in a timely manner.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example the practice did not have effective procedures in place to deal with alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA) or alerts related to patient safety.
- The practice did not have adequate arrangements in place to ensure controlled drugs were stored in line with legislation.
- Health and safety risks to patients and staff were assessed and managed including the risk of fire.
- Some patient outcomes were in line with local and national averages. However the practice was an outlier when compared with other practices in the clinical commissioning group for a number of areas including referrals to secondary care.

Summary of findings

- Limited audit and quality improvement work had been undertaken within the practice. Although there was evidence of the practice comparing their performance to others, this was driven by the CCG rather than practice led.
- Although some audits had been carried out in relation to referrals to secondary care, we saw limited evidence that audits were driving improvements to patient outcomes.
- Patients were generally positive about their interactions with staff and said they were treated with compassion and dignity.
- The practice had some leadership structures however there was insufficient leadership capacity and formal governance arrangements needed to be strengthened.
- Information about the performance of the practice was not shared widely with appropriate staff within the practice.

The areas where the provider must make improvements are:

- Ensure patients receive safe care and treatment by; investigating significant events and safety incidents in a timely way including documentation of the findings and dissemination of the learning; ensuring the safe storage and management of medicines including controlled drugs; implementing effective systems and processes for disseminating and acting upon alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- The provider must have effective systems in place to assess and monitor the quality of the service by ensuring they have effective oversight of the performance of the practice and the effectiveness of the clinical care being provided.For example by ensuring internal meetings allow for discussion and learning from events and complaints and by ensuring there is leadership capacity to deliver all improvements.

In addition the provider should:

- Review and update policies and procedures
- Carry out completed clinical audits cycles to improve patient outcomes.
- Improve arrangements for recording of and responding to verbal complaints.
- Review and improve arrangements for the provision of minor skin surgery procedures.
- Continue to try and improve the identification of carers.
- Ensure all documents related to the recruitment of staff are retained and available for review.
- Consider how to improve the engagement of members of the clinical staff team with the patient participation group (PPG).

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Process for reporting and recording significant events were not being operated effectively. Staff were not clear about the process for reporting incidents, near misses and concerns. Although the practice carried out some investigations when there were unintended or unexpected safety incidents, lessons learned were not always communicated and so safety was not improved.
- Patients were at risk of harm because systems and processes were not implemented in a way which kept them safe. For example, there was no clear process in place to deal with medicines alerts. The practice did not have effective systems in place to respond to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Systems to store and monitor the stock levels of controlled drugs were not operated effectively within the practice.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. There was a dedicated child safeguarding lead who liaised with community staff.
- Health and safety risks to patients and staff were assessed and well managed.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Data showed patient outcomes were in line with local and national averages for some indicators. For example the practice's achievement in the Quality and Outcomes Framework for 2015/16 was in line with local and national averages.
- Data from the clinical commission group (CCG) showed the practice was an outlier for referrals to secondary care and non-elective admissions.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 81% and the national average of 80%.

Summary of findings

- Computer based templates which were based on national guidelines were not used consistently by clinical staff within the practice to aid staff to deliver effective care.
- There was limited evidence that audit was driving improvement in patient outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice in line with others for most aspects of care. For example, 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- Feedback from comment cards and patient we spoke with indicated patients felt they were treated with compassion, dignity and respect.
- Information for patients about the services available was easy to understand and accessible.
- During our inspection, we saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Feedback from staff at the care home to which the practice was aligned was positive about the care and respect shown to their residents.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- The practice had reviewed the needs of its local population and made improvements including plans for the development of their branch practice.
- Patients said they were generally able to make an appointment with a GP with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice offered a minor surgery clinic for patient to access services to remove skin tags and lesions. However, we were not assured that this service was being operated effectively and in a timely way with some patients having been on a waiting list for over a year.
- Information about how to complain was available and easy to understand. Evidence showed the practice responded promptly

Summary of findings

to issues raised in writing. However, there was no system in place to record verbal complaints and concerns meaning the practice could not be assured it was learning from all feedback and identifying trends.
- There was limited evidence to show that learning from complaints was shared with staff.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice did not have a clear vision and strategy. Although some plans were in place for the future there were limited mechanisms in place to enable plans to be shared with staff. Staff were not clear about their responsibilities in relation to the vision or strategy.
- Understanding of performance of the practice was limited and was not routinely shared with relevant staff within the practice.
- There was a leadership structure in place but we were not assured there was adequate leadership capacity to drive improvement. For examples the practice had been an outlier in respect of their referrals to secondary care for a number of years and had not made significant improvements in this area.
- The practice had a number of policies and procedures to govern activity. However, some policies and procedures were not up to date and these were not managed effectively.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- Staff told us they had not received regular performance reviews and did not have clear objectives. All staff had received inductions but not all staff attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for the care of older people. However, we saw some examples of positive care.

- The practice was responsive to the needs of older people and offered home visits and urgent appointments where required.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line with local and national averages, for example in relation in to osteoporosis.
- Patients aged 75 years and over had a named GP to provide continuity of care.
- Influenza, pneumococcal and shingles vaccinations were offered in accordance with national guidance.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for the care of people with long-term conditions. However, we saw some examples of positive care.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- Clinical staff working within the practice had limited awareness of the performance of the practice in respect of long-term conditions.
- Performance for diabetes related indicators was 100% which was 11.2% above the CCG average and 10.1% above the national average. Exception reporting rates for all indicators used to measure the management of diabetes were above local and national averages.
- Performance for COPD related indicators was 100% which was 6% above the CCG average and 4.1% above the national average. Exception reporting rates for all indicators used to

Summary of findings

measure the management of COPD were above local and national averages. For example, the achievement for the percentage of patients with COPD with a record of FEV1 in the previous 12 months was 93% which was 11.1% above the CCG average and 7.1% above the national average. However, the exception reporting rate for this indicator was 40.7% which was 27.3% above the CCG average and 24.6% above the national average. The percentage of patients who received this intervention was 15.6% below the CCG average and 16.9% below the national average.

- The practice's rate of non-elective admissions for patients with COPD was significantly above the CCG average. In addition the practice had higher rates of re-admission after 30 days and 90 days.
- Patients had named GPs and were offered structured annual reviews to check their health and medicines needs were being met.

Families, children and young people

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for the care of families, children and young people. However, we saw some examples of positive care.

- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and same day appointments were available for children who were unwell.
- The premises were suitable for children and babies.
- We saw positive examples of joint working with community based staff.
- The practice had a dedicated child safeguarding lead and most staff had received safeguarding training at a level appropriate to their role.
- The practice offered some family planning services including implant fitting.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive

Summary of findings

services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for the care working age people (including those recently retired and students). However, we saw some examples of positive care.

- Extended hours services were provided one evening per week to facilitate access for working age people.
- The practice offered some online services including access to appointments and prescribing.
- The practice had a website which offered health promotion information.
- Patients could access telephone advice and a triage service was operated two days per week.
- Uptake rates for national cancer screening were in line with local and national averages.

People whose circumstances may make them vulnerable

Inadequate 

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is therefore rated as inadequate for the people whose circumstances may make them vulnerable (including those recently retired and students). However, we saw some examples of positive care.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability and for those who required them.
- Vulnerable patients were informed about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice had a carers register and had identified 0.7% of the patient list as carers.

People experiencing poor mental health (including people with dementia)

Inadequate 

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone

Summary of findings

using the practice, including this population group. The practice is therefore rated as inadequate for people experiencing poor mental health (including people with dementia). However, we saw some examples of positive care.

- Performance for mental health related indicators was 85.6% which was 8% below the CCG average and 7.2% below the national average. Exception reporting rates for all indicators used to measure the management of mental health were below local and national averages.
- 97.7% of patients diagnosed with dementia had their care plan reviewed face to face in the previous 12 months which 11.1% above the CCG average and 14% above the national average. This was achieved with an exception reporting rate of 6.4% which was below local and national averages.
- Feedback from the local care home that cared for residents with dementia was positive about their interactions with the practice.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We reviewed the results of the national GP patient survey which were published in July 2016. The results showed the practice was performing in line with local and national averages for most indicators. A total of 222 survey forms were distributed and 121 were returned. This was a 55% response rate and represented 2% of the practice's patient list.

Results showed:

- 71% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 76% and the national average of 73%.
- 78% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 85% and the national average of 85%.
- 84% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 79% of patients said they would recommend this GP practice to someone new to the area compared to the CCG average of 78% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received three completed comment cards which were positive about the standard of care received.

We spoke with five patients and a member of the patient participation group (PPG) during our inspection. Patients were generally satisfied with the care they received and thought staff were kind and caring.

Areas for improvement

Action the service MUST take to improve

- Ensure patients receive safe care and treatment by; investigating significant events and safety incidents in a timely way including documentation of the findings and dissemination of the learning; ensuring the safe storage and management of medicines including controlled drugs; implementing effective systems and processes for disseminating and acting upon alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- The provider must have effective systems in place to assess and monitor the quality of the service by ensuring they have effective oversight of the performance of the practice and the effectiveness of the clinical care being provided. For example by ensuring internal meetings allow for discussion and learning from events and complaints and by ensuring there is leadership capacity to deliver all improvements.

Action the service SHOULD take to improve

- Review and update policies and procedures
- Carry out completed clinical audits cycles to improve patient outcomes.
- Improve arrangements for recording of and responding to verbal complaints.
- Review and improve arrangements for the provision of minor skin surgery procedures.
- Continue to try and improve the identification of carers.
- Ensure all documents related to the recruitment of staff are retained and available for review.
- Consider how to improve the engagement of members of the clinical staff team with the patient participation group (PPG).

Clay Cross Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. On each visit the team included a GP specialist adviser and a second CQC inspector.

Background to Clay Cross Medical Centre

Services are provided from a main practice located at Bridge Street, Clay Cross, Derbyshire S45 9NG. The practice had a branch surgery located at Queen Victoria Road, Tupton, S42 6TD. We did not visit the branch practice as part of our inspection.

The level of deprivation within the practice population is slightly above the national average with the practice. Income deprivation affecting children is below the national average and income deprivation affecting older people is slightly above the national average.

The clinical team comprises two GP partners (one male, one female), one salaried GP (male), a clinical pharmacist, an advanced nurse practitioner, two practice nurses and two healthcare assistants. The clinical team is supported by a practice manager, a deputy practice manager and a team of reception and administrative staff.

The main practice is open between 8am and 6.30pm Monday to Friday. Appointments at this practice are from 8.30am to 11.30am every morning and from 3pm to 5.30pm daily. Extended hours appointments are available on Tuesdays from 6.30pm to 7.45pm.

The practice does not provide out-of-hours services to the patients registered there. During the evenings and at weekends an out-of-hours service is provided by Derbyshire Health United. Contact is via the NHS 111 telephone number.

The practice was previously inspected in September 2015 and was rated as requires improvement overall; specifically the practice was rated as requires improvement for providing safe, effective and well-led services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The practice had previously been inspected in September 2015 and found to be requires improvement for providing safe, effective and well-led services and good for providing caring and responsive services. We undertook a further comprehensive inspection in November 2016 to ensure the provider has made improvements. The provider was found to be in breach of Regulation 19 of the Health and Social Care Act 2008 due to concerns regarding the absence of background checks undertaken for staff acting as chaperones. Following this inspection, the provider was issued with a requirement notice and provided an action plan to the CQC.

Detailed findings

How we carried out this inspection

Before our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out announced visits on 2 November 2016 and 10 November 2016.

During our visits we:

- Spoke with a range of staff (including GPs, nursing staff, the practice manager, the assistant practice manager and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and 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?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The systems in place to enable staff to report and record significant events were not being operated effectively.

- The practice had a significant event protocol in place but this was not being followed by all staff.
- Not all staff were aware of how to report incidents or events or whom to report these to.
- Significant events were not reported in a timely manner. We saw evidence of significant events which had not been reported or discussed for over a year.
- Not all staff were aware of where to find a template to record a significant event and we saw that different templates were being used by different members of staff.
- Documentation related to significant events was not always completed. For example, we reviewed records of documents which noted the incident but did not document the action taken in response to the incident.
- There was limited evidence of significant events being reviewed on an ongoing basis. A significant event review meeting had been held in November 2015 but not all significant events had been reviewed at this meeting. A further meeting was planned for November 2016 and the agenda demonstrated that two significant events from October 2015 were due to be discussed.
- Seven significant events, dating from October 2015 to October 2016, were scheduled to be discussed in November 2016; the practice could only provide evidence of two of these having been discussed or reviewed prior to this. This was not in line with the practice's protocol which indicated a meeting would be held after the event had been investigated and a review would be undertaken.
- We were not assured that the practice had effective systems and processes in place to ensure that all incidents were investigated thoroughly in a timely manner.

Systems to manage alerts received by the practice related to patient safety and alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were not being operated effectively. There was no policy or protocol in place to govern how the practice responded to alerts. We were told that alerts were received by the practice manager and disseminated to staff as required. However, staff we spoke with were unclear about who had responsibility for taking any required action in response to alerts. Although copies of alerts received were stored on the practice's shared drive, there was no system to record action taken in response to these.

A review of the patient record system showed a number of patients were being prescribed contraindicated medicines. For example, there were four patients being prescribed high doses of a lipid lowering medicine with a medicine for treating high blood pressure. We reviewed records for two patients who were prescribed these medicines after the MHRA 2012 alert meaning the prescriber would have had to override a system generated warning; there was no clear rationale on the records as to why the medicines continued to be prescribed.

Overview of safety systems and processes

The practice had some systems and processes in place to keep patients safe and safeguarded from abuse. However, there were areas where improvements needed to be made.

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff on the practice's computer system; however, there were a number of different versions of policies and it was unclear which ones staff should be referring to when guidance was required. For example, we were provided with two copies of the safeguarding children policy, one of which indicated it last been reviewed in 2014 and the other which indicated it had been reviewed in 2016. Staff were aware of safeguarding leads. The policies outlined who to contact for guidance if staff had concerns about a patient's welfare. There was a lead GP for child safeguarding and a lead GP for adult safeguarding.
- The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3.
- Notices were displayed in the waiting room to advise patients that they could requested a chaperone if required. All staff who acted as chaperones had undertaken training for the role and had 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).

- During our inspection, we observed the practice to be clean and tidy. Appropriate arrangements were in place to maintain standards cleanliness and hygiene. The advanced nurse practitioner was the infection control clinical lead and was supported in this role by the practice nursing team. There were an infection control policies and protocols in place and staff had received date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- Some of the arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines.
- The practice employed a pharmacist and worked regularly with the local CCG pharmacy team to review prescribing. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We saw that there were systems in place to store blank prescription forms and pads securely each evening. However, during opening hours, the blank prescription paper for use in printers was kept in an open box in the office area. Prescribers were able to take blank prescription paper from this box as required meaning that there was no effective system in place to monitor its use in line with guidance.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse); however they did not have procedures in place to manage them safely in line with controlled drugs regulations. The practice had standard operating procedures in place to govern their management of controlled drugs. These had not been reviewed or updated since 2013 and did not name which GP had responsibility for the controlled drugs within the practice.
- The standard operating procedures in place were not being followed in the practice. For example, the key for the controlled drug cupboard was not kept separately from other keys.
- We identified other areas of concerns related to the management of the practice's controlled drugs. For example, the controlled drugs were not recorded in an appropriate register. The practice told us they kept an electronic register of controlled drugs; although this was not specified in their standard operating procedures. We found that the practice had two spreadsheets on the practice's shared computer drive entitled 'controlled drugs register' and controlled drugs register new'. The spreadsheets were accessible to any members of staff via the shared drive and were not password protected and therefore balances could be amended and there was an increased risk of misappropriation.
- The controlled drugs were stored inside a metal box which was stored in a locked alarmed cupboard. Controlled drugs should be stored in a metal controlled drugs cupboard which should be bolted to the floor or an external wall. The metal box stored inside the cupboard was not secured to the cupboard and the key to the box was attached to the box with blu-tack.
- Following our inspection, we have received assurance that the practice has destroyed their stock of controlled drugs in accordance with legislation.
- We reviewed three personnel files for staff appointed since our last inspection. Most recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, the practice manager was unable to provide, when requested, documentary evidence of satisfactory conduct in a previous role for two members of staff. The practice manager told us this had been requested but had either not been added to the file or had not been received.

Monitoring risks to patients

Most risks to patients were assessed and managed

- There were processes in place to monitor and manage risks to patient and staff safety. There was a health and safety policy statement available with a poster in the reception office which identified local health and safety representatives.

Inadequate

Are services safe?

- The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Rotas were used to plan and monitor the number and mix of staff needed to meet the needs of patients and ensure enough staff were on duty. A number of staff referenced there not being enough clinical staff to meet the needs of patients. Locums were used to provide cover where required but providing cover for nurses and healthcare assistants was more challenging with one healthcare assistant having recently reduced their hours. The nursing staffing had recently been reviewed by an external individual who had recommended the recruitment of a treatment room nurse. This had been welcomed by nursing staff and recruitment was underway at the time of the inspection.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to respond to emergencies and major incidents. These included:

- There was a messaging system on the computers in all the consultation and treatment rooms which alerted staff to emergencies.
- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- A first aid kit and accident book were available. We noted there were no recorded entries in the accident book.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage; however, one GP we spoke with was not aware of the plan. The plan included emergency contact numbers for staff and suppliers.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- Clinical staff had access to training to support them in remaining up to date with guidelines from NICE.
- Meeting minutes from the last 12 months did not show evidence of discussion or dissemination of guidelines.
- The practice had access to computer based templates on the clinical system which incorporated guidelines. We saw evidence that these templates were used by nursing staff but discussions with GPs and a review of records indicated that they were not being used routinely by GPs.
- We did not see evidence of any audits being conducted within the practice to consider if guidelines were being met.

Management, monitoring and improving outcomes for people

Although the practice collected information for the Quality and Outcomes Framework (QOF) there was no evidence that this information was regularly reviewed and used to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Staff we spoke with did not have a comprehensive understanding of the practice's achievement within QOF. There was no lead GP responsible for oversight of QOF performance meaning that there was no coordinated approach to QOF achievement.

The most recently published QOF results demonstrated that the practice had achieved 98.1% of the total number of points available which was 3.2% above the CCG average and 2.8% above the national average. The practice had an overall exception reporting rate within QOF of 16%. This was 6.9% above the CCG average and 6.2% above the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.)

QOF data from 2015/16 showed performance was in line with local and national averages. However, exception reporting rates for some areas were significantly above local and national averages:

- Performance for diabetes related indicators was 100% which was 11.2% above the CCG average and 10.1% above the national average. Exception reporting rates for all indicators used to measure the management of diabetes were above local and national averages. For example, the achievement for patients newly diagnosed with diabetes being referred to structured education within nine months was 100% which was 13.8% above the CCG average and 7.6% above the national average. However, the exception reporting rate for this indicator was 85.2% which was 55.7% above the CCG average and 62.2% above the national average.
- Performance for COPD related indicators was 100% which was 6% above the CCG average and 4.1% above the national average. Exception reporting rates for all indicators used to measure the management of COPD were above local and national averages. For example, the achievement for the percentage of patients with COPD with a record of FEV1 in the previous 12 months was 93% which was 11.1% above the CCG average and 7.1% above the national average. However, the exception reporting rate for this indicator was 40.7% which was 27.3% above the CCG average and 24.6% above the national average. The percentage of patients who received this intervention was 15.6% below the CCG average and 16.9% below the national average.
- Performance for mental health related indicators was 85.6% which was 8% below the CCG average and 7.2% below the national average. Exception reporting rates for all indicators used to measure the management of mental health were below local and national averages.
- 97.7% of patients diagnosed with dementia had their care plan reviewed face to face in the previous 12 months which 11.1% above the CCG average and 14% above the national average. This was achieved with an exception reporting rate of 6.4% which was below local and national averages.

Data provided by the CCG demonstrated that the practice was an outlier in a number of areas:

- The practice was 24% overspent in relation to their prescribing budget which was significantly higher than other practices in the local area. A prescribing action plan was in place at the time of the inspection.
- Data for 2015/16 demonstrated that the practice was an outlier for referrals to secondary care. The average number of referrals made per month per 100 patients was 27; this was above the CCG average of 18.
- The rate of non-elective activity for 2015/16 was above the CCG average. Data showed that the average activity

for the practice was 19 per 100 patients; this was above the CCG average of 13. The practice was consistently ranked first or second highest in the CCG for non-elective activity for the six months to April 2016.

- Data demonstrated that the care of patients with COPD was not being effectively managed in the practice. The practice had the highest rate of non-elective admissions to hospital for patients with a diagnosis of COPD. In addition, the practice had the highest rate of re-admission to hospital within 30 days and 90 days. The practice had 35 non-elective admissions for 2015/16 with a 30 day readmission rate of 31% and a 90% re-admission rate of 37%. The average 30 day re-admission rate was 16% and the average 90 day re-admission rate was 20%.

There was limited evidence of quality improvement including clinical audit.

- We were provided with copies of two clinical audits undertaken in the last two years; one of these was a completed audit where the improvements made were implemented and monitored.

Effective staffing

There were some systems in place to ensure staff had the skills, knowledge and experience to deliver effective care and treatment.

- Inductions were provided for new members of clinical and non-clinical staff. Inductions covered general topics including health and safety, safeguarding, infection control, fire safety and confidentiality in addition to more role-specific training.
- Staff were supported to access role-specific training and updates as required to cover the scope of their role. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines stayed up to date with changes to the immunisation programmes through access to on line resources and discussion at nurse meetings.
- The practice facilitated access to a range of training they considered to be mandatory including safeguarding, fire safety, basic life support and information governance. Staff had access to e-learning training modules and in-house training. Other training needs were identified informally through meetings, discussions and appraisals.
- Staff received training that included safeguarding, fire safety, basic life support and information governance. Staff had access to e-learning training modules and in-house training.

Coordinating patient care and information sharing

Staff were able to access the information they needed to plan and deliver care and treatment through the practice's patient record system. This included care and risk assessments, care plans, medical records and investigation and test results. The assistant practice manager also acted as care coordinator for the practice and was responsible for the administration of the practice's 'virtual ward'. The virtual ward system enabled the practice to manage their most vulnerable patients and meetings were held on a weekly basis to discuss these patients.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services. The practice worked closely with their community matron to meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

Care plans for patients receiving end of life care were shared the out of hours care provider to ensure that the needs of these patients were met when the practice was closed. The practice told us meetings had been held regularly to discuss patients on the palliative care register however, at the time of the inspection; there had been no meeting to discuss patients on the palliative care register since May 2016.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Following the previous inspection, staff had undertaken training in the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Inadequate

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the clinician assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice sought to identify patients who may need additional support. These included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to relevant services.

Data from QOF for 2015/16 demonstrated the practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 81% and the national average of 80%. The practice's exception reporting rate for cervical screening was 8.2% which was above the CCG average of 3.8% and the national average of 6.5%. The practice offered reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice's uptake rate for breast cancer screening was 73% which was in line with the CCG average of 74% and the national average of 72%. The practice's uptake rate for bowel cancer screening was 60% which was in line with the CCG average of 60% and the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93% to 100% and five year olds from 98% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed members of staff were polite and helpful towards patients and treated them with dignity and respect.

Measures were in place within the practice to help patients feel at ease and to maintain their privacy and dignity. These included:

- Curtains were provided in consulting and treatment rooms to maintain patients' privacy and dignity during examinations and treatments.
- Consultation and treatment room doors remained closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff had undertaken equality and diversity training.

We received three completed Care Quality Commission comment cards as part of the inspection. All of these were positive about the level of service they received from the practice. Patients described practice staff as caring and helpful.

We spoke with five patients including one member of the patient participation group (PPG). Feedback from patients was generally positive about the care they received and they felt treated with dignity and respect.

Results from the national GP patient survey, published in July 2016, showed patients felt they were treated with compassion, dignity and respect. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses and interactions with reception staff. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 85%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Most patients told us they felt involved in decision making about the care and treatment they received. Feedback from patients was mixed in respect of having enough time during appointments with some patients feeling rushed. Most patients told us they felt listened to and supported by staff. Patient feedback from the comment cards we received was positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were marginally above local and national averages. For example:

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Translation and interpretation services could be accessed if required for patients who did not have English as a first language.
- Some information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

A range of information leaflets and posters were displayed in the waiting area. These informed patients about how they could access local and national support groups and organisations.

The practice encouraged carers to make themselves known to practice staff and they maintained a register of carers which was overseen by their carers' champion. The practice had identified 43 patients as carers which was equivalent to 0.7% of their patient list. There was information available on the website and in the waiting area to make carers aware of the various avenues of support available to them.

Staff told us that if families experienced bereavement, their usual GP contacted them where appropriate. This contact was followed by a consultation or with advice on how to contact support services as required.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they considered the needs of their local population and sought to make improvements to services where a need for these was identified. For example, the practice had identified a need for additional clinical capacity but had been unable to recruit another GP. In response to this, the practice had recruited an advanced nurse practitioner and a clinical pharmacist to help meet the needs of the patients. The practice was also in the process of recruiting a treatment room nurse following an external staffing audit of the nursing team.

In addition:

- Plans were being made for improvements to the practice's branch site at Tupton to increase the number of consulting rooms and increase clinical capacity.
- The practice offered extended hours appointments one evening per week to facilitate access for working patients.
- Patients could access appointments at the main surgery or the branch surgery and GPs worked across both sites to afford choice to patients.
- There were longer appointments available for patients with a learning disability and for those who required them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The premises were suitable for patients with a disability with level access, dedicated parking for patients with a disability and accessible toilets.
- Text message reminders were sent to patients for appointments. Online appointment booking and cancellation was also available.

However, there were areas where the service being offered was not meeting the needs of patients.

- The practice provided a minor surgery service to patients; this included the provision of a service to remove skin tags and warts. We reviewed the waiting list for procedures and found that some patients had been on the waiting list since February 2015. Twenty-seven patients had been on the waiting list since 2015. Staff were unsure when a minor surgery clinic had last been held however patients continued to be added to the waiting list. At the time of the inspection, there were over 40 patients on the waiting list. Some patients were classified as 'first priority when the next clinic is on' or 'urgent' but there was no clear rationale in their medical records as the reason for the prioritisation. There was an absence of evidence of communication with patients about waiting times and no plans in place as to when the patients could expect to receive treatment.
- The practice had a website which offered patients a range of information and services. However, there was out of date information on the website which indicated that there was a still a branch surgery at Wingerworth which had been closed for some time. There was no information related to the closure of the branch site on the website. The telephone number listed for the branch site was no longer in service.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11am each morning and from 3pm to 5.30pm each afternoon. Extended hours appointments were offered at the following times on Tuesday evenings until 8pm. Pre-bookable appointments could be booked up to four weeks in advance and urgent appointments were available on the day. Each clinician had three emergency appointments available each morning and each afternoon with the afternoon appointments being released from 2pm. The practice operated a triage system two days per week.

Results from the national GP patient survey, published in July 2016, showed that patient's satisfaction with how they could access care and treatment was in line with or slightly below local and national averages. For example:

- 75% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and the national average of 76%.
- 70% of patients described their experience of making an appointment as good compared to the CCG averages of 75% and the national average of 73%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 78% of patients were able to get an appointment to see of speak to someone the last time they tried compared to the CCG average of 85% and the national average of 85%.
- 71% of patients said they could get through easily to the practice by phone compared to the CCG average of 76% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

Systems were in place to assess to manager requests for home visits. This included whether home visits were clinically necessary; and the urgency of the need for medical attention. Requests for home visits were managed by the assistant practice manager and monitored throughout the day. Requests were flagged to the duty doctor or a specific clinician where appropriate. In cases where it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

Some systems were in place to handle complaints and concerns.

- The practice had complaints policies and procedures which were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- Information was available to help patients understand the complaints system including information available on the website and in the waiting area.

We looked at three complaints received in the last 12 months and found these were responded to appropriately and in a timely manner. However, there was no effective system in place to record verbal concerns received within the practice. Although issues related to care and treatment were recorded in a patient's record, for example in relation to a prescription delay or waiting times for minor surgery; these were not logged centrally. This meant that the practice had limited capacity to identify trends or issues. The practice could not provide, when requested, evidence of discussion of complaints at clinical meetings. Complaints were not reviewed on an annual basis.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice told us they prided themselves on being an approachable and accessible practice. Although the aims and values of the practice were not outlined in the practice leaflet or on the website staff told us they were committed to providing good care for their patients. The practice's statement of purpose defined the aim of the practice to be to provide primary care treatment to the best possible standard. The way the practice was led and governed did not always enable the practice values to be delivered effectively.

- The practice's future plans were not formalised in a business plan or development plan. However, some senior staff were able to tell us about plans for the future including the development of the branch site and recruitment of additional staff.
- The practice did not hold regular, dedicated meetings to discuss business matters or make plans for the future meaning there was no plan as to how the practice was going to realise their plans for the future.
- A number of areas for improvement had been identified as a result of the previous inspection. The practice had developed an action plan in response to this but not all areas of the action plan had been completed and there was no evidence to demonstrate that the plan was monitored or reviewed on an ongoing basis. For example, an area identified within the plan for improvement was the use of standard computer based templates to aid the monitoring and management of a number of major conditions; the plan indicated that this had been completed on 26 November 2015 and discussed in a significant event meeting. However, a review of minutes did not show a record of this being addressed at the meeting. Furthermore, discussions with staff and a review of patient records demonstrated that templates were not being used consistently.
- The clinical commissioning group (CCG) had identified a number of areas for improvement based on their ongoing programme of visits and performance reviews. For example, we saw evidence that the practice's high rate of referrals to secondary care had been highlighted in early 2014. We were informed that the practice was offered assistance with developing an action plan but this was declined. The initial action plan which was shared with us and had been submitted to the CCG was not sufficiently detailed. Although the plan outlined the areas to address it did not include specific actions or supporting information to provide detail on how these would be progressed or any progress to date.
- During our second visit we were provided with a copy of a further action plan which was dated 10 November 2016. This document detailed a number of areas of concerns which included referrals, urgent activity and prescribing. The plan contained more detail but there were no clear timescales.

Governance arrangements

There were limited governance arrangements in place to support the delivery of care within the practice.

- There was a clear staffing structure within the practice and staff were aware of the general roles and responsibilities of colleagues.
- The practice had a range of policies and procedures available for staff on the shared drive.
- We found limited evidence that the practice proactively managed their own performance, including a local review of comparative data. For example, there was no evidence of review or discussion in respect of QOF achievement. Discussions with staff demonstrated that they had limited awareness of the overall performance of the practice in respect of QOF. Areas for improvement were identified and led by the CCG which provided support to the practice to try to address these.
- When work had been undertaken to improve performance in areas where the practice was an outlier, this lacked a co-ordinated approach. For example two of the GPs were meeting informally to discuss referrals; however, the third GP did not attend these meetings. In addition, one GP had audited their referrals over a short period of time but this had not been undertaken in relation to the referrals of the other GPs.
- There were some arrangements to identify, record and manage risks. However, there were areas where improvements needed to be made. For example, there was no clear process or protocol being operated in relation to the action required in response to alerts about medicines and patient safety. In addition, not all staff were aware of how to report and record significant events. There were limited mechanisms in place to ensure that significant events and incidents were properly investigated and learning identified.

Are services well-led?

Inadequate

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

Leadership and culture

During our inspection, we were not assured that senior staff in the practice had the capacity and capability to run the practice and ensure high quality care.

The practice told us they encouraged a culture of openness and honesty; however processes for staff to raise issues or report incidents were not being operated effectively. The practice manager assured us that people affected by incidents would be given support, information and apologies where required. Although written correspondence was retained, records of verbal correspondence were only kept within the patient record system. This limited the practice's ability to analyse any trends in respect of concerns raised verbally.

There was a leadership structure in place and most staff felt supported by management.

- Staff told us the practice had held regular meetings but that these had not been happening regularly recently. We were told that meetings had started again the previous month and we saw meeting minutes to support this.
- We saw evidence of regular meetings within the nursing team and some meetings within the administrative team. However, there was limited evidence of teams working together in a coordinated manner.
- Staff told us they would not hesitate to raise issues with colleagues in their team and could raise issues if needed with the practice manager.
- Staff said they felt respected, valued and supported by their colleagues in the practice. There was a relatively low turnover of staff with a number of staff having worked for the practice for some time.
- Staff had recently been involved in about how to improve the practice and all members of staff had been encouraged to identify opportunities to improve the service delivered by the practice.
- Practice staff had not received formalised support through appraisals in the last 12 months. A number of staff told us they had never received a formal appraisal. This meant we could not be assured that staff were being provided with sufficient opportunities to learn and develop in their roles.
- The practice had been receiving support from a local practice to review some areas of performance.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged feedback from patients. It sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through the national GP patient survey and complaints and comments received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG reviewed the results of the national GP patient survey and developed an action plan with the practice as a result. Feedback from the PPG was generally positive about the practice and their interactions with the practice manager. However, the PPG told us they had never had clinician involvement in their meetings and felt this would be beneficial.
- The practice gathered feedback from staff informally through meetings and discussions; although these were sporadic in nature. An external review of nursing staffing had also been undertaken as nursing staff had been consulted as part of this. Following this, the practice was in the process of recruiting a new treatment room nurse.
- Staff told us they would not hesitate to discuss any concerns or issues with colleagues.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was failing to ensue that care and treatment was being provided in a safe way for service users. Specifically the provider was not ensuring that all risks to service users were assessed and mitigated. For example, the provider was not ensuring that they were complying with alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA).