

Whitmore Reans Health Practice

Quality Report

Whitmore Reans Health Centre
Lowe Street, Whitmore Reans
Wolverhampton
West Midlands
WV6 0QL
Tel: 01902 421679
Website: www.drvijandpartners.nhs.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	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Requires improvement	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

The provider, Whitmore Reans Medical Practice have practices at three locations in Wolverhampton: Whitmore Reans Health Practice; Ednam Road Surgery and Pendeford Health Centre. Although all three are currently registered separately with the Care Quality Commission (CQC), they share one overall registered patient list. Ednam Road Surgery and Pendeford Health Centre operate as branch surgeries, with patients able to visit any of the three practices in order to access primary medical services. This inspection focused on Whitmore Reans Health Centre which was the main location.

We inspected Whitmore Reans Health Practice, Whitmore Reans Health Centre, Lowe Street, Wolverhampton, WV6 0QL on 5 December 2014 as part of a comprehensive inspection. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective and well-led services. The areas for improvements that led to these

ratings also applied to all of the six population groups that we inspect. These are, people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health. We rated the practice good for providing a caring and responsive service.

Our key findings were as follows:

- The systems in place to ensure patients received a safe service were not robust.
- There were examples of evidence based practice which was referenced in patients care and treatment to ensure positive outcomes were achieved. However, the arrangements in place to identify, review and monitor patients with some long term conditions were not always effective.
- Patients were complimentary about the staff at the practice and said they were caring, listened and gave them sufficient time to discuss their concerns.

Summary of findings

- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups and the practice pro-actively engaged with patients in the local community to promote good health.
- We identified during the inspection areas for improvements such as recruitment procedures and effective systems for reviewing patients with long term conditions. This demonstrated that governance arrangements at the practice should be improved. The leadership structure in place were not clearly defined and some of the staff members were at times uncertain about their roles and responsibilities.

However, there were also areas where the practice needs to make improvements.

Importantly, the provider must

- Operate effective recruitment procedures and ensure that the information required under current legislation is available in respect of all staff employed to work at the practice.

In addition the provider should:

- Ensure significant events are documented in detail to show learning and reflection.
- Review arrangements to assess, manage and monitor the needs of patients with a diagnosis of dementia and those receiving end of life care. The practice should ensure appropriate follow up is provided to patients receiving NHS health checks carried out by other services and those recently discharged from hospital.
- Ensure that the needs of patients who may have difficulty accessing the service are taken into consideration.
- Develop a robust process for the monitoring of training in order to provide assurance that staff have the knowledge and skills they need to deliver care safely and effectively.
- Review the governance arrangements at the practice to ensure clear leadership structures.

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?

The practice is rated as requires improvement for providing safe services. There was evidence example of regular checks of emergency medicines and equipment and information. Guidance was available on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately reported and investigated. Staff understood and fulfilled their responsibilities in reporting incidents, including significant events. However, recruitment processes were not sufficiently robust to ensure that the information required under current legislation was available in respect of all staff employed to work at the practice.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services. Clinical audits were completed to ensure patients' care and treatment was effective. There were examples of evidence based practice which was referenced in patients care and treatment to ensure positive outcomes were achieved. The arrangements in place to identify, review and monitor patients with some long term conditions and those in high risk groups were not always effective and must be improved as this could result in patients not receiving the care and support that they need.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services. Patients said that staff were caring and understanding and their privacy and dignity was respected. Patients told us that staff listened and gave them sufficient time to discuss their concerns and they were involved in making decisions about their care and treatment.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had arrangements in place to respond to the needs of specific patient groups. There were vaccination clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated. One of the GPs visited a local mosque to educate people on diabetes. We saw leaflets on managing diabetes and stopping smoking during Ramadan (the month of fasting for Muslims). The practice was responsive to complaints with evidence demonstrating that they acted on issues raised in a proactive manner.

Good



Summary of findings

Are services well-led?

The practice is rated as requires improvement for being well-led. The practice had a vision and was working towards delivering this. The practice had a number of policies and procedures to govern activity and these were regularly reviewed and updated as necessary. There was evidence of improvements made as a result of audits and feedback from patients. However, the governance arrangements at the practice were not robust and the leadership structure was not clear.

Requires improvement



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

The provider was rated as requires improvement for safety, providing effective services and being well-led. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of older people.

The practice was in the process of allocating patients over 75 years of age a named GP. This is an accountable GP to ensure patients over the age of 75 years receive co-ordinated care.

There were arrangements to review patients in their own home if they were unable to attend the practice. We spoke with a manager at a local nursing home who provided positive feedback on the service received from the practice.

Requires improvement



People with long term conditions

The provider was rated as requires improvement for safety, providing effective services and being well-led. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people with long-term conditions.

Patients with long term conditions were reviewed by the GPs and the nurses to assess and monitor their health condition so that any changes to their treatment could be made. The practice had clinics where staff reviewed and managed patients with diabetes. Health checks and medication reviews took place and repeat prescriptions were accessible. These arrangements would help to minimise unnecessary admissions to hospital. However, the arrangements in place to identify, review and monitor patients with some long term conditions and those in high risk groups were not always effective.

Requires improvement



Families, children and young people

The provider was rated as requires improvement for safety, providing effective services and being well-led. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of families, children and young people.

Requires improvement



Summary of findings

Antenatal care was provided by the midwife who undertook clinics at the practice. Post natal checks were completed by GPs to ensure a holistic assessment of women's physical and mental wellbeing following child birth. Women were offered cervical screening and there were systems in place to audit results.

Children under the age of 5 years had access to the Healthy Child Programme. The practice had an allocated health visiting team who were based within the health centre. This enabled good working relationships and systems in place for information sharing. Safeguarding procedures were in place for identifying and responding to concerns about children who were at risk of harm.

Working age people (including those recently retired and students)

The provider was rated as requires improvement for safety, providing effective services and being well-led. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of working age people (including those recently retired and students).

The practice had extended opening hours on Mondays and Fridays when the practice was open from 3pm until 8pm which would benefit working age patients. Patients were able to book appointments by telephone and order repeat prescriptions by telephone or on line. Telephone consultations were available so patients could call and speak with a GP or a nurse where appropriate if they did not wish to or were unable to attend the practice.

Opportunistic health checks and advice were offered such as blood pressure checks and advice on stop smoking and weight management. NHS health checks were available for people aged between 40 years and 74 years. However, these were undertaken by an external service and there was no follow up system in place to ensure findings were acted on.

Requires improvement



People whose circumstances may make them vulnerable

The provider was rated as requires improvement for safety, providing effective services and being well-led. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

Requires improvement



Summary of findings

The practice was part of a shared care scheme which meant that one of the GPs worked closely with the local substance misuse service to support patients with recovery from drug dependency.

The practice provided an enhanced service to avoid unplanned hospital admissions. This service focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical services contract (GMS). Annual health checks were undertaken for patients with a learning disability.

People experiencing poor mental health (including people with dementia)

The provider was rated as requires improvement for safety, providing effective services and being well-led. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

Patients with serious mental illnesses were offered an annual review of their physical and mental health needs, including a review of their medicines. There was an alert system on patient's electronic records to highlight to staff any high risk patients who were at risk of self-harm.

Staff worked with local community mental health teams to ensure patients with mental health needs were reviewed, and that appropriate risk assessments and care plans were in place.

Requires improvement



Summary of findings

What people who use the service say

We looked at results of the most recent national GP patient survey 2013, the survey results covered all three practices. Out of the 459 surveys sent 114 were completed and returned. Findings of the survey were based in comparison to the average for other practices nationally. The results of the national GP survey highlighted the practices were worse than average in a number of areas in comparison to other practices nationally. This included patients overall experience of their GP practice, being involved in decisions about their care and being treated with care and concern by the GP. The practices scored amongst the worst for the proportion of patients who would recommend their GP surgery.

We reviewed comments made on the NHS Choices website to see what feedback patients had given over the last year. There were seven comments posted on the website in the last year, of these five contained positive feedback which included access to appointments and friendly staff. There were two negative comments relating

to difficulty getting through on the telephone and poor attitude of some of the staff. The practice had replied to both of the negative comments in a constructive manner which showed that the practice took the opportunity to engage and listen to patient feedback to improve the quality of the service.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 15 completed cards, the feedback we received was overall positive. On the day of the inspection we spoke with ten patients including one member of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients described staff as caring and helpful and said their privacy and dignity was respected. However, patients told us that access to appointments and the length of time they waited to be seen by the GP on arrival at the practice needed to improve.

Areas for improvement

Action the service **MUST** take to improve

- Operate effective recruitment procedures and ensure that the information required under current legislation is available in respect of all staff employed to work at the practice.

Action the service **SHOULD** take to improve

- Ensure significant events are documented in detail to show learning and reflection.
- Review arrangements to assess, manage and monitor the needs of patients with a diagnosis of dementia and

those receiving end of life care. The practice should ensure appropriate follow up is provided to patients receiving NHS health checks carried out by other services and those recently discharged from hospital.

- Ensure that the needs of patients who may have difficulty accessing the service are taken into consideration.
- Develop a robust process for the monitoring of training in order to provide assurance that staff have the knowledge and skills they need to deliver care safely and effectively.
- Review the governance arrangements at the practice to ensure clear leadership structures.

Whitmore Reans Health Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a specialist advisor GP and a specialist advisor practice manager with experience of primary care services.

Background to Whitmore Reans Health Practice

Whitmore Reans Health Practice is based in a purpose built health centre shared with other health care services. The practice is the main location with two branch surgeries in the Wolverhampton area which are Ednam Road Surgery and Pendeford Health Centre. The registered patient list size across all three practices is approximately 12,000 patients.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as for example, chronic disease management and end of life care. The practice also provided some enhanced services. An enhanced service is a service that is provided above the standard general medical services contract (GMS).

Whitmore Reans Health Practice is open Mondays to Fridays from 8.30am to 1.30pm and then from 3pm to 7pm on Tuesdays to Thursdays. There are extended opening hours on Mondays and Fridays when the practice is open from 3pm until 8pm which would benefit working age patients. The practice has opted out of providing

out-of-hours services to their own patients. This service is provided by 'Prime care' the external out of hours service contracted by the local Clinical Commissioning Group (CCG).

The staffing establishment at Whitmore Reans Health Practice includes staff who work across all three practices and consists of four GPs (two male and two female). There is one salaried GP and three GP partners although at the time of our inspection only two of the GPs have registered with the Care Quality Commission (CQC). There are two long term locum GPs who work on a sessional basis. The practice employs three practice nurses (female) and one advance nurse practitioner (ANP) (female). There are also twelve administrative staff and two practice managers. The practice is a teaching practice for final year medical students.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in one of most deprived areas in Wolverhampton. As the practice also had two branch surgeries some of the data that we reviewed incorporated all three practices Data showed that there is a lower than average patient population aged 65 years and over and an above average patient population aged between 20 to 34 years in comparison to other practices across England. The provider achieved 99.7 points for the Quality and Outcomes Framework (QOF) for the last financial year 2012-2013. This was above the average practice score nationally. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

Detailed findings

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. This 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. This provider had not been inspected before and that was why we included them.

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.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice. We also asked other organisations to share what they knew. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 15 completed cards where patients shared their views and experiences of the service. We carried out an announced visit on 5 December 2014. During our inspection we spoke with a range of staff including the management team, clinical and non clinical staff. We spoke with patients who used the service. We observed the way the service was delivered but did not observe any aspects of patients care or treatment.

Are services safe?

Our findings

Safe track record

Patients spoken with did not report any safety concerns to us and we were not aware of any major safety incidents that had occurred at the practice.

Patient safety alerts were reviewed and actioned where appropriate and shared with staff and there was evidence to support this. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on.

There were systems in place to report any incidents that occurred at the practice. Discussions with staff demonstrated that they were aware of the process for incident reporting and they told us they received feedback following incidents during meetings and we evidence to support this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. We found that staff were encouraged to report incidents and nine significant events had been recorded in the last six weeks. Findings were recorded, discussed and shared with staff in meetings. However, some significant events were not documented in detail to show good learning and reflection of significant events.

Reliable safety systems and processes including safeguarding

There were arrangements in place for ensuring patient safety, this included safeguarding policies and procedures and contact numbers for local safeguarding teams for staff to refer to should they have any concerns. There was a lead GP for safeguarding and an alert system was in place to highlight vulnerable adults and children. We saw evidence that most of the clinical staff had received level 3 safeguarding children training. This level of training would help to develop knowledge, skills and the ability to work collaboratively on the processes for safeguarding and promoting the welfare of children. We saw that there were gaps in training and not all of the staff had received training

in safeguarding adults and children. However, our discussions with staff demonstrated that they were aware of the action to take if they suspected someone was at risk of harm.

Some of the non clinical staff we spoke with said that they acted as chaperones and they had completed online training in this area. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Staff we spoke with said that they had completed training and were aware of their role and responsibilities when undertaking this duty and there was a policy in place to guide staff.

Medicines management

There was a dedicated secure fridge where vaccines were stored. There were systems in place to ensure that regular checks of the fridge temperature was undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature ranges. The practice did not store any controlled drugs.

The practice routinely used electronic prescribing and where a paper prescription was used a system was in place so that the prescription could be accounted for.

There were arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure medications remained relevant to their health needs. Protocols were in place to provide staff with guidance and ensure consistency.

A pharmacist from the local Clinical Commissioning Group (CCG) was attached to the practice, this enabled medicine management systems such as repeat prescribing to be monitored and reviewed. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The most recent data available to us showed that the practice prescribing rates for a number of medicines were in line with the national average and prescribing rates for a specific type of medicine were better than the national average.

Cleanliness and infection control

On the day of our inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection. This included the

Are services safe?

availability of personal protective equipment (PPE), colour coded cleaning equipment and disposable privacy curtains that were clearly dated and showed that they had been recently changed.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed to help staff monitor how long they had been in place. A contract was in place to ensure the safe disposal of clinical waste.

The general environment was cleaned by an external cleaning contractor. There were cleaning schedules in place that included daily, weekly and monthly tasks so that cleaning was consistently maintained. The practice manager told us that the building was a shared building and owned by NHS property services and they were responsible for monitoring the standard of cleaning and undertook spot checks. We saw sheets which indicated that reviews of the cleaning had taken place but it was not clear what aspects of cleaning had been reviewed and by whom.

An external audit on infection prevention and control had been completed in February 2014. The practice had achieved a general score of 95 % and a score of 93% in the area of minor surgery. We saw that most of the actions identified from the audit had been addressed such as repairs to the room used for minor surgery. There was a nurse lead for infection prevention and control and we saw that they had undertaken a hand washing audit for all clinical staff in November 2014 to ensure that standards of hand hygiene were being monitored.

The practice manager was unable to show us training records that demonstrated staff had received training in infection prevention and control, although our discussion with staff demonstrated their understanding of good infection control procedures. Infection prevention and control policies and procedures were available for staff to refer to enable them to comply with relevant legislation. Staff told us that these policies and procedures were accessible to them.

One of the managers told us that NHS property services who owned the premises regularly flushed all of the water outlets to reduce the risk of legionella, a term for particular bacteria which can contaminate water systems in

buildings. There was a policy in place but the practice was unable to demonstrate that they had assured themselves that a competent person routinely checked, inspected and cleaned the system, in accordance with the practice policy.

Equipment

Records showed that medical equipment had been calibrated and electrical appliances had been tested to ensure they were in good working order and safe to use. There was evidence that fire alarms and equipment were tested.

Staffing and recruitment

The registered patient list size across all three practices was approximately 12,000 patients. The staffing at Whitmore Reans Health Practice consisted of four permanent GPs and two long term locum GPs who worked on a sessional basis. The practice also employed three practice nurses and one advance nurse practitioner (ANP). There were twelve administrative staff and two practice managers.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. Staff, including nursing and administrative staff were able cover each other's annual leave. Staff sometimes worked across all three practice and could be mobilised across the practices when needed to cover any shortages

The GPs covered each other's leave and regular locum GPs were employed where necessary to ensure continuity in patients care.

We looked at three staff files which included the file of two of the most recently employed members of staff. There was evidence that some of the appropriate pre-employment checks were completed as part of the recruitment procedure. This included details of professional registration and a Disclosure and Barring Service (DBS) check. The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. However, we saw that there was missing information which the managers and the lead GP were unable to locate. For a new member of clinical staff there was no medical health information including immunisation status for hepatitis B, references, or proof of identity. A new member of non clinical staff had started their post before any reference had been sought to determine conduct in their previous employment. Non clinical staff had no DBS checks although they acted as chaperones. A chaperone is

Are services safe?

a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The practice had no system in place to risk assess the different responsibilities and activities of the staff to determine if they were eligible for a DBS check and to what level. We looked at the file of one of the regular locum GPs. We saw that some of the appropriate documentation was sought prior to them working at the practice such as a DBS check, details of their professional registration, indemnity insurance and checks to ensure they were included on the national performers list. However, there was no evidence to confirm that references and proof of identity had been obtained. There was no evidence that appropriate agreements were in place with the locum agency so that the practice was able to assure themselves that these checks had been completed.

Monitoring safety and responding to risk

There were arrangements to deal with foreseeable medical emergencies. A number of staff had received training in responding to a medical emergency. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely in the

event of a medical emergency. The practice had oxygen and automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff we spoke with (including receptionists) knew the location of the emergency medicines and equipment.

The practice manager told us that NHS properties were responsible for fire checks of the premises. We saw that a fire risk assessment was in place which covered potential hazards and a health and safety assessment had been completed. Staff had received training in fire safety and fire drills took place to ensure staff were prepared in the event of a fire emergency.

Arrangements to deal with emergencies and major incidents

The practice had an up to date business continuity plan in place. This covered a range of areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service. There were contact details of staff and main suppliers that would be needed in the event of an emergency and major incident.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians we spoke with were able to describe and demonstrate how they accessed and implemented guidelines based on best practice such as National Institute for Health and Care Excellence (NICE) for example in the management of diabetes. NICE provides national guidance and advice to improve health and social care.

We saw that some clinics were held for patients with long term conditions. For example, patients with diabetes had annual reviews by the nurse with specialist knowledge in diabetes at dedicated clinics. Patients with a learning disability were also invited for an annual review with the GP and nurse and given an extended appointment to ensure sufficient time for completing the assessment. The practice did not have specific clinics to review patients with other long term conditions such as asthma, hypertension and heart disease. We were told that the practice identified and recalled patients during normal surgery time and if the practice was not achieving its target then specific clinics would be held.

We found the system in place for identifying and reviewing patients with some long term conditions was not always effective. There were nine patients who were on the palliative care register however, we found that regular multi-disciplinary meetings were not taking place. Data that we reviewed from Public Health England showed that the practice was worse than average for dementia diagnosis rate adjusted by the number of patients in residential care. We identified that the arrangements to assess, manage and monitor the needs of patients with a diagnosis of dementia was not effective. The practice had 26 patients with a diagnosis of dementia on a register. However, the register was not up to date and there was no evidence of annual reviews for this patient group to ensure a holistic assessment of the person's individual needs including a discussion with their carers.

The practice had started a scheme to avoid unplanned hospital admissions by providing an enhanced service. An enhanced service is a service that is provided above the standard general medical services contract (GMS). This focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. However, we found that the

arrangements for care and support for patients recently discharged from hospital was not always effective. At the time of the inspection the practice had identified the required 2% of high risk patients however, not all of these patients had care plans in place and the correct codes were not in place to identify and follow up patients following discharge from hospital. We saw that the practice had started an audit to review the system in place however, there was analysis of the data as yet as the audit had not been completed.

The practice had identified that there were 750 patients who were over the age of 75 years and were in the process of informing these patients who their named GP was to ensure they received co-ordinated care.

There were arrangements to review patients in their own home if they were unable to attend the practice for diagnosis and medication monitoring purposes.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included the treatment of patients with diabetes and prevention of stroke in patients with a specific heart condition. Some of the audits were still in progress and therefore not completed cycles. However, we were told that re-audits would take place to demonstrate the improvements made to patients care and treatment.

The childhood vaccination programme was undertaken by the practice nurse. The most recent data available to us showed that the percentage of children receiving some of the childhood vaccinations were below the average for the CCG area. We discussed this with the nurse at the time of the inspection who told us that this could be explained by practice population some of whom were mobile and often had moved before further vaccinations were due. We saw information about the childhood vaccination programme was displayed in the patient waiting area to raise awareness of the importance of having these vaccinations. Data shown to us on the day of the inspection demonstrated that the practice had achieved 90% uptake of childhood vaccinations to date.

The lead GP told us that the only minor surgery that they carried out were joint injections and this was undertaken at the branch surgeries.

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff spoken with on the day of the inspection said that they were given the opportunity and supported to develop specialist knowledge and expertise. For example, one of the nurses had completed a course in diabetes. There was no training log for clinical staff to provide assurance that staff were up to date with their training and additional training needs could be easily identified. However, we saw training certificates in two clinical staff files in areas such as safeguarding children, responding to a medical emergency and domestic abuse.

There was a training log for non clinical staff which showed training that staff had completed in areas such as fire safety, data protection and responding to a medical emergency. We identified gaps and inconsistencies in the training records for example, there were no details of training in areas such as infection control, adult and children's safeguarding and the Mental Capacity Act (2005). However, staff we spoke with confirmed that they had received training in areas relevant to their role such as chaperoning.

New staff received induction training to help prepare them for their role.

The practice had systems in place for annual appraisals for all staff including the GPs and we saw evidence of completed appraisals.

The GPs who worked at the practice had undergone external revalidation of their practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise medicine.

Working with colleagues and other services

We found that there were no recent meetings with relevant healthcare professionals as part of Gold Standard Framework (GSF) for end of life care which the lead GP told us was due to funding issues. This framework ensures a multi-disciplinary approach to end of life care based on best practice ensuring care that is compassionate and dignified.

NHS Health checks were available for people aged between 40 years and 74 years. However, these checks were completed by an external service. We saw no evidence that systems were in place to ensure appropriate follow up was provided to patients receiving NHS health checks carried out by the external service.

There was a national recall system in place for cytology screening in which patients were invited to attend the practice. Cytology screening was undertaken by the practice nurse. This ensured women received this important health check including their results in a timely manner and findings were audited to ensure good practice was being followed.

There were systems in place to ensure that the results of tests and investigations were reviewed and actioned as clinically necessary by the GPs. Incoming results were entered on to the computer system and each clinician was responsible for reviewing those that they had requested with cover arrangements in place for when a GP was on leave.

Information sharing

The practice referred patients appropriately to secondary and other community care services such as district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen.

Our discussion with a practitioner involved in supporting patients with substance misuse issues suggested that there were good arrangements with the GP for reviewing and managing these patients effectively.

Patients who were receiving end of life care had a named GP and there were systems in place to share information with out-of-hours services for when the practice was closed.

Consent to care and treatment

Not all of the staff had received training on the Mental Capacity Act (2005) to ensure that they were up to date with current guidance. The Mental Capacity Act (2005) is a law that protects and supports people who do not have the ability to make decisions for themselves. However, two of the GPs had attended relevant training and were therefore aware of the Mental Capacity Act (2005). One of the GPs was also developing a policy to support staff. We saw that there was flow chart on the Mental Capacity Act that provided some guidance. All of the clinical staff we spoke with were able to demonstrate understanding of Gillick competency when assessing children under the age of 16 and demonstrated their understanding of capacity assessments and how the principles would be applied in practice.

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

Information leaflets and posters were available in the patient waiting area relating to health promotion and prevention. This included health conditions and advice on choosing the most appropriate service for effective treatment and advice.

The practice offered advice and support in areas such as smoking cessation, weight management, travel advice and family planning. There were arrangements in place for NHS

health checks for people aged between 40 years and 74 years. The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance.

The practice had a procedure in place for new patients registering with the practice, this included completing a new patient medical assessment. However, we found the registration form lacked detail and there were gaps in the form which meant that key information such as NHS health checks, details for next of kin and carers was missing.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Our discussions with patients on the day and feedback from comment cards told us patients felt that staff were caring and their privacy and dignity was respected.

Results of the national GP survey showed that the practice was average for the number of patients who stated that they could not be overheard in the reception area. We observed that there were some arrangements in place to maintain confidentiality. There was a privacy screen between the patient waiting area and the reception desk and a poster requesting patients not to approach the desk if someone else was there. Some of the patients we spoke with commented that this was effective in ensuring their confidentiality was maintained when speaking to reception staff. We saw that a number of staff had received training in patient confidentiality. A poster on data protection was displayed raising patient's awareness of the issue. We did not see any information informing patients that they could discuss any issues in private away from the main reception desk. However, we observed staff to be careful in what they discussed with patients approaching the reception desk and staff took incoming calls away from the desk so that sensitive information could not be overheard.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations.

Patients were offered a chaperone for intimate examinations. Our discussions with staff demonstrated that they were aware of the importance of maintaining patient's dignity and respect during such procedures.

There were two permanent female GPs working at the practice; this gave patients the option of receiving gender specific care and treatment.

Care planning and involvement in decisions about care and treatment

The results of the national GP survey showed that the practice was worse than average in comparisons to other practices nationally for patients being involved in decisions about their care and for being treated with care and concern by the GP. We saw that the practice had taken

some action in response to these results such as clinicians undertaking face to face customer service training to promote empathy and compassion. Two of the GPs had attended modules at a university on higher consultation skills with learning disseminated to the clinicians in the practice. The practice results for nursing consultations showed that they were average.

Most of the patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us 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 they wished to receive. Feedback on the comment cards we received was also positive and aligned with these views. However, a small proportion of patients told us that they felt rushed during their consultation as they could only discuss one health issue at a time. We discussed this with the managers who told us that this was to try and reduce the length of wait for other patients as patients often booked a single appointment and would want to discuss multiple issues. Feedback we received on the day and results from the last national GP survey demonstrated that patients felt they waited a long time to be seen for their appointment.

The practice had access to interpreting services for patients who did not speak English as their first language. The self-check system allowed patients to register in a number of languages.

Patient/carer support to cope emotionally with care and treatment

We saw that there were nine patients who were receiving end of life care. We asked staff about bereavement support for patients. They told us that clinical staff attended meetings with relevant professionals and agencies to discuss and review patients who were receiving end of life care based on the national gold standard framework (GSF). However, we found that there were no recent meetings, a meeting took place in January 2014 and the last meeting took place in March 2014. The GPs told us that they were no longer participating in GSF due to funding issues and would now be undertaking telephone discussions with relevant health care professionals. We found that there was no alert on the patient record system highlighting patients receiving end of life care so that they could be easily identified by staff.

Are services caring?

The GPs told us that in the event of a patient death they would ring or visit the family member or carer to offer support. We saw that leaflet were available in the patient waiting area on bereavement services. There were also arrangements in place to refer patients to specialist services if necessary.

We saw a poster in the patient waiting area encouraging patients to let staff know that they were carers to ensure their needs were identified and support could be offered. There was a carer's information leaflet with contact details of local support groups.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found aspects of the service were responsive to people's needs with systems in place to maintain the level of service provided. The practice delivered core services to meet the needs of the main patient population they treated. For example screening services were in place to detect and monitor the symptoms of long term conditions such as diabetes. There were vaccination clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated.

There was evidence that the practice was responsive to its practice population. One of the GPs visited a local mosque to educate people on diabetes. We saw leaflets on managing diabetes during Ramadan (the month of fasting for Muslims). This ensured people who were at high risk of diabetes due to their ethnic background were targeted to help promote good health.

We saw that the practice had a patient participation group (PPG), which covered all three practices. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. We spoke with a member of the PPG who told us that the group met regularly. There was evidence that the PPG group had acted on feedback from patients. As a result of patient feedback improvements had been made in the telephone system at Whitmore Reans practice which included more telephone lines. The PPG recognised the need to recruit new members who were reflective of the practice population. The PPG had identified further actions required as result of feedback from the GP patient survey which included the length of time patients waited to be seen for their appointment.

Tackling inequity and promoting equality

The practice had access to an interpreting service for patients whose first language was not English, this included a telephone translation service. The 'Self-Check' service in the patient waiting could be translated into a number of languages.

The practice managers told us they had not carried out an audit to identify physical barriers and to make reasonable adjustments for people who may have difficulty accessing the service. As a result they had not identified issues such

on entering the practice one set of doors was not automatic and could cause difficulty for a person in a wheelchair. There was also no system in place to ensure patients could get assistance. The reception desk did not have a low level area which would enable patients who required the use of a wheelchair to speak with staff easily.

There were no baby changing facilities at the practice which would be helpful for parents with babies and young children.

Access to the service

We looked at the appointment system at the practice. We saw that appointments were available in advance as well as urgent appointments. Home visits were undertaken for those patients who were unable to attend the practice. One of the GPs also undertook a monthly visit to a nursing home to review patients needs. Telephone consultations were available so that any patients who had urgent queries could speak to a GP or a Practice Nurse. Patients attending for annual reviews such a patient with learning disability was given a double appointment to ensure sufficient time was available.

Completed comment cards and discussions with patients on the day suggested that the practice should improve access to appointments and reduce the length of time patients waited to be seen by the GP on arrival to the practice. Our discussions with staff and some of the patients indicated that patients often came with multiple health problems and this contributed to the delay. We saw that the practice was exploring this further through the PPG and the practice had undertaken a recent in-house survey which included this issue.

Whitmore Reans Health Practice was open Mondays to Fridays from 8.30am to 1.30pm and then from 3pm to 7pm on Tuesdays to Thursdays. There were extended opening hours on Mondays and Fridays when the practice was open from 3pm until 8pm which would benefit working age patients. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service 'Prime care' contracted by the CCG. The practice manager told us that when the practice was closed during core hours general medical service cover was provided by the out of hours provider. The answer phone message informed patients to contact the NHS 111 service or the out of hours service provider when the practice was closed.

Are services responsive to people's needs?

(for example, to feedback?)

We saw that the practice had a number of patients who did not attend their appointments (DNA). This was identified by an audit on DNA rates. We were told that telephone text message reminders were sent to patients regarding their appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The system included a complaint log which covered complaints from all three practices. We saw that there were 10 complaints in the last year across all three

practices. The complaints log did not distinguish which practice the complaint related to although staff told us that they would be able to identify this based on the postcode of the patient. There was evidence that complaints were discussed and shared with staff. A complaints leaflet was available which provided information on the complaints procedure.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. However, none of the patients we spoke with had needed to make a complaint about the practice

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The lead GP and staff we spoke with demonstrated the values of the practice and a commitment to improving the quality of the service for patients. The GP partners had plans to develop and expand service provision for the future, although these plans had not been formally documented. This included establishing the practice as a training practice for GP registrars (fully qualified doctors who wish to become general practitioners) and working more effectively with other practices in the local area.

Governance arrangements

Records showed that some of the essential risk assessments had been completed such as fire and business continuity plans, where risks were highlighted measures had been put in place to minimise the risks.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at some of these policies and procedures and found that they had been reviewed and were up to date.

The GPs at the practice had various lead roles in areas such as diabetes, safeguarding and women's health. This provided the opportunity for staff to develop specialist knowledge and expertise. Data that we reviewed showed that the practice was on target to achieve its QOF for the current financial year 2014 to 2015.

Leadership, openness and transparency

The staff we spoke with told us that they felt valued and well supported. However, the leadership structure in place was not clearly defined and some of the staff members were at times uncertain about their roles and responsibilities and gave conflicting information. Whitmore Reans Health Practice had two practice managers; in addition managers from the branch surgeries also worked cross site. We found that this sometimes caused confusion in relation to who was responsible for what and we received conflicting information during the course of the inspection. For example, one of the managers told us that there were no QOF meetings and the other told us that there were. One manager told us they did not do over 75 checks the other said that they did. We were told that a new IT system had been implemented which had caused some disruption to the delivery of the service however, the

managers gave different accounts of when the system was introduced. We identified during the inspection areas for improvements such as recruitment procedures and effective systems for reviewing patients with long term conditions. The QOF figures for the practice were at times inconsistent and discussions with the managers demonstrated a lack of understanding of some of the processes in places. For example, there was evidence that staff were not applying the appropriate codes on the computer system consistently. This could result in patients with specific health needs not being identified. It was apparent that a lack of clear leadership was a contributing factor to some of the areas for improvement.

The practice had a whistle blowing policy and staff told us that they felt confident to raise any concerns about poor care that could compromise patient safety. Whistleblowing is when staff are able to report suspected wrong doing at work confidentially, this is officially referred to as 'making a disclosure in the public interest'.

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

We saw that the practice had acknowledged and responded to feedback from patients which on the NHS choices website and via complaints. This showed that feedback raised had been considered and reflected upon.

The practice had a PPG and there was some evidence that they had acted on patient feedback which had resulted in changes although further work was required to implement more effective changes. The practice manager and GP partner attended PPG meetings to ensure they remained fully involved and aware of feedback from patients. The practice had recently completed an in-house survey and we were told that findings would be analysed and acted on.

The practice gathered feedback from staff generally through appraisals, meetings and informal discussions. Staff we spoke with told us that they felt listened to and supported.

Regular staff meetings were held to ensure staff were kept informed and up to date with relevant information.

Are services well-led?

Requires improvement 

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

Management lead through learning and improvement

The GPs and practice manager demonstrated throughout the inspection process that they were proactive in their approach to improving the quality of service provided. The practice was able to demonstrate the use of clinical audit audits to measure performance and analyse outcomes.

Learning from complaints, significant events and audits were shared with staff to help learning and improvements. However, significant events were not always are documented in detail to show learning and reflection.

There was evidence that teaching and training was encouraged and supported for example one of the nurses had been supported to complete a diploma in diabetes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>We found that the registered person did not operate an effective recruitment procedure. Appropriate checks were not always completed prior to staff commencing their post. This included medical health information, evidence of conduct in previous employment and DBS checks. The registered person did not ensure that information specified in Schedule 3 was available.</p> <p>This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (1) (a) (c) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	