Apsley Surgery

Inspection report

Cobridge Community Health Centre
Church Terrace
Stoke on Trent
Staffordshire
ST6 2JN
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

We previously carried out an announced, comprehensive of Apsley Surgery on 20 August 2015 and rated the practice as good overall and in all five key questions.

The full comprehensive report for the inspection in August 2015 can be found by selecting the 'all reports' link for Apsley Surgery on our website at www.cqc.org.uk.

We carried out an announced, comprehensive inspection at Apsley on 4 February 2020 as part of our inspection programme.

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as requires improvement overall and in effective and well-led, inadequate in safe and good in effective and caring. We rated each population group as good except for families, children and young people and working age people which we rated as requires improvement.

We rated the practice as **inadequate** in safe because:

- There were gaps in staff training. For example, safeguarding, fire safety and fire marshal.
- All the required risk assessments had not been completed to mitigate potential risks.
- Alerts had not been added to the records of the parents of a child with a child protection plan in place. The practice was unable to hold regular meetings with health and social care professionals, to protect vulnerable adults and children at risk of harm due to circumstances outside of their control.
- All the required recruitment documents were not available for all members of staff employed by the practice. DBS checks or risk assessments to mitigate potential risks had not been completed for non-clinical staff particularly those who chaperoned.
- A formal system of clinical review of the prescribing competence of three non-medical prescribers was not in place. However, following our inspection the practice forwarded to us evidence of how this would be completed.
- Opportunities to raise significant events had been missed. A system for recording and reviewing significant events over time to identify trends was not in place.
- Not all staff had received the immunisations appropriate to their role. Used sharp's boxes had not been collected within three months after first use, even if not full.
- Sharp's boxes were not available at the branch practice.
- The in-house fire risk assessment completed for the branch practice had failed to identify two risks.
- Fire drills had not been carried out at the branch practice.
- The legionella risk assessment for the branch practice showed there were 12 areas that need to be addressed. However, there was no evidence to demonstrate that 11 of these areas had been completed.
- The system for tracking prescription stationery throughout the branch practice was not effective.
- The practice did not hold all the suggested emergency medicines at the main or branch practice. Risk assessments for all the missing medicines had not been completed.
- Oxygen, airway management equipment for children and a defibrillator were not available at the branch site. A risk assessment to mitigate potential risks to patients had not been completed.

We rated the practice as **requires improvement** in effective because:

- The practice had not met the minimum 90% target for all four childhood immunisation uptake indicators. The uptake of the immunisation for haemophilus influenza type b and meningitis C booster was significantly below target.
- Screening rates for breast cancer and bowel cancer were below local and national averages.
- Cervical screening rates were significantly below the national target.

We rated the practice as **good** in caring because:

- Staff treated patients with kindness, respect and compassion.
- The practice respected patients' privacy and dignity.

We rated the practice as **good** in responsive because:

- The practice organised and delivered services to meet patients' needs.

Overall summary

- People were able to access care and treatment in a timely way.

We rated the practice as **requires improvement** in well-led because:

- Systems for identifying, managing and mitigate risks were ineffective.
- Governance meetings including clinicians had not been established.
- An overarching system to review trends in significant events and complaints over time was not in place.
- Staff did not know or understand the practice's vision, values and strategy.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure specified information is available regarding each person employed.

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

- Explore and implement strategies to increase the uptake of childhood immunisations, breast and bowel cancer screening.
- Review the effectiveness of strategies implemented to increase the uptake of cervical screening.
- Establish in-house safeguarding meetings to protect vulnerable adults and children.
- Ensure information regarding how to complain is readily available for patients to access within the practice.
- Support staff to understand the practice's vision, values and strategy.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Apsley Surgery

Apsley Surgery is located in Stoke-on-Trent and provides services from their main practice at Cobridge Community Health Centre, Church Terrace, Stoke-on-Trent, Staffordshire, ST6 2JN and their branch practice at 62 Knypersley Road, Norton, Stoke on Trent, ST6 8HZ. We visited both of these locations during our inspection. The practices have good transport links and there are pharmacies nearby.

The provider is registered with the CQC to deliver the Regulated Activities; diagnostic & screening procedures, treatment of disease, disorder or injury, maternity and midwifery services and surgical procedures. The practice was updating their partnership registration with the CQC to include a non-clinical business partner and a GP partner.

Apsley Surgery is situated within the Stoke-on-Trent NHS Clinical Commissioning Group (CCG) and provides services to approximately 6,600 patients under the terms of a Provider Medical Services (GMS) contract. A PMS contract is a locally agreed, fixed term contract for delivering general medical services with the option to vary the terms of the contract to meet the needs of the local community.

The practice employs one male GP partner (currently unregistered with the CQC), five long-term locum GPs, two nurse practitioners and a locum nurse practitioner, one practice nurse, two health care support assistants, a practice director and business partner, a practice manager and assistant practice manager and nine administrative staff covering a range of hours.

The practice area is one of very high deprivation when compared with the national and local CCG area. Demographically 24.9% of the practice population is under 18 years old which is higher than the national average of 20.6% and 11.9% are aged over 65 years which is lower the national average of 17.4%. The general practice profile shows that the percentage of patients with a long-standing health condition is 45.6% which is lower than the local CCG average of 55% and the national average of 51%. The National General Practice Profile describes the practice ethnicity as being 76.2% white British, 16% Asian, 2.9% black, 3.1% mixed and 1.8% other non-white ethnicities. Average life expectancy is 75 years for men and 80 years for women compared to the national average of 79 and 83 years respectively.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met.** **The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:** • Governance meetings including clinicians had not been established. • An overarching system to review trends in significant events and complaints over time was not in place.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met.** **The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:** • Disclosure and Barring Service checks for non-clinical staff particularly staff that chaperoned. Risk assessments to mitigate potential risks had not been completed. • A full employment history, together with a satisfactory written explanation of any gaps in employment. • Satisfactory information about any physical or mental health conditions which are relevant to the person's ability to carry on, manage or work for the purposes of, the regulated activity.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. A warning notice was issued. **How the regulation was not being met.** Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • Staff without the required immunity to healthcare associated infections. • Lone working. • Missing suggested emergency medicines at both the branch and main practice. • No oxygen or airway management equipment for children at the branch practice. • No defibrillator at the branch practice. • The in-house fire risk assessment at the branch practice had failed to identify that regular fire drills had not been completed or that the nominated fire marshal had not completed appropriate training to carry out this role. • The legionella risk assessment for the branch practice showed there were 12 areas that need to be addressed. However, there was no evidence to demonstrate that 11 of the required actions had been completed. There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular: • Not all staff had received the immunisations appropriate to their role. Risk assessments to mitigate potential risks were not in place. • Used sharp's boxes had not been collected within three months after first use, even if not full.

This section is primarily information for the provider

Enforcement actions

- Sharp's boxes were not available at the branch practice for the disposal of sharps.

There was additional evidence that safe care and treatment was not being provided. In particular:

- There were gaps in staff training including safeguarding, fire safety and fire marshal.
- A formal system of clinical review of the prescribing competence of three non-medical prescribers was not in place.
- Fire drills had not been carried out at the branch practice.
- The system for tracking prescription stationery throughout the branch practice was not effective.
- Alerts had not been added to the records of the parents of a child with a child protection plan in place.