Blue Dykes Surgery

Quality Report

Eldon Street, Clay Cross, Chesterfield, Derbyshire
S45 9NR
Tel: 01246 866771
Website: www.bluedykessurgery.co.uk

Date of inspection visit: 4 August 2015
Date of publication: 10/12/2015

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?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Blue Dykes Surgery on 4 August 2015. Overall the practice is rated as requires improvement. Specifically, we found the practice inadequate for providing safe services. It was rated as good for providing, effective, responsive, and caring services and requires improvement for being well led services. The evidence which led to us rating the practice requires improvement potentially affects all population groups and we have therefore rated 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 and people experiencing poor mental (including people with dementia) as requires improvement. Our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. The systems and processes in place to ensure good governance were ineffective and did not enable the provider to assess and monitor the quality of the services and identify, assess and mitigate against risks to people using services and others.
- At the time of the inspection, patients were at risk because there was insufficient clinical capacity to ensure key tasks were undertaken in a timely manner and by staff who had the appropriate clinical skills to make safe decisions. This included taking action in response to letters and making changes to medicines as requested by secondary care and triaging letters coming into the practice from other providers. The practice immediately addressed this issue and cleared the backlog of correspondence.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.

Summary of findings

- Urgent appointments were available on the day they were requested. Patients said that they sometimes had to wait a long time for non-urgent appointments with a GP of their choice.
- The recruitment processes were not robust and did not ensure that patients received care and treatment from staff who had been fully checked to confirm they were suitable to work with them.

The areas where the provider must make improvements are:

- Ensure there are effective systems designed to identify, assess and mitigate against risk, for example in respect of concerns with infection prevention and control.
- Ensure that there are effective systems in place to assess and monitor the quality of the service being provided; for example by ensuring audits of practice are undertaken, including completed clinical audit cycles.
- Ensure processes to deal with clinical letters from other agencies, detailing the changes needed to patient's medications are robust, actioned timely and by the appropriate staff.
- Ensure a system is in place to give oversight ensuring all the required employment checks are carried out for all staff to ensure they are suitable to work with patients.
- Ensure that all staff are trained appropriate to their role and that training records are kept.
- Ensure robust systems are in place to manage and store stocks of medicines to minimise the risk of out of date medicines and dressing being used.
- Strengthen the system that would ensure that learning from significant events, and near misses was recorded, learning shared, and improvements made.

In addition the provider should;

- Ensure that the practice has an approved safeguarding policy implemented.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

The practice was not able to demonstrate that it had a safe track record over time or that it had systems and processes in place that would monitor, evaluate, and share learning to give assurance that risks were managed to keep patients safe. We found that the practice had failed to prescribe medicines within a safe time frame when requested by secondary care colleagues. In addition, non-clinical staff had responsibility for amending prescribed medicines. The practice had not undertaken appropriate recruitment checks to ensure that staff providing care to patients had the necessary qualifications to do so safely. The system in place to manage medical or safety alerts did not record that any actions needed to be taken to keep patients safe was taken, recorded, and monitored. There was not a robust learning culture from significant events or audit to ensure that the services delivered to patients are safe and appropriate.

Are services effective?

Good

The practice is rated as good for providing effective services.

The nationally publish data for quality and outcome framework (QOF) for April 2013 to March 2014 showed the practice achieved 87.7% of the total points. This was below the CCG average of 95.6% and below the England average of 94.8%. Data verified by NHS England but not published showed the practice performance had improved and had achieved 417 out of 435 clinical points. The practice had implemented changes to the recall system which the data supports had shown improvements.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients told us they were treated with compassion, dignity, and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect; in a caring manner and that their confidentiality was respected and maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice had responded to the challenge of limited availability of GP staff and had developed a new model of care to try and address their recruitment challenges. The practice offered late appointments for patients who were working The practice offered NHS health checks for patients to promote healthy lifestyles and offered advice for health promotion to help keep patients healthier.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services, as improvements need to be made.

The practice did not have sufficient leadership capacity to provide assurance that there were effective systems in place to ensure governance and oversight of the quality of the service and risks to patients and others were identified, assessed, and mitigated against. The practice leaders acknowledged that systems and processes were limited or absent and needed significant strengthening. There were a number of areas where the absence of effective systems did not provide partners with the service oversight needed to assure them that their service was delivering safe patient care. The practice did hold regular staff meetings, however there was no assurance from those meetings that learning was extracted and that it translated into changes that would improve and sustain changes to the services delivered to the patients.

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

Requires improvement

The provider was rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Home visits were available for those who were unable to attend the practice, although these were often with an advance nurse practitioner. The nurses visited patients in their own homes for annual reviews for those with long term conditions. Longer appointments were available when needed. Patients who required palliative care were visited by the GPs. The practice provided a routine weekly visit to a local care home. The manager of the care home told us that the GPs provided good care to their service users.

Data showed the practice performance,

• For osteoporosis, was the maximum it could achieve at 66.66% for both 2013-2104 and 2014-2015.

• For stroke the practice performance was 85.3% this was 10.7% below the CCG average and 11.0% below the England average. This improved to 85.3% in 2014 - 2015. There was no comparable data for 2014 - 2015.

People with long term conditions

Requires improvement

The provider was rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had a team of nurses who specialise in the long term conditions, with one of them being responsible for housebound patients and those in nursing or residential homes. Patients with long term conditions were offered appointments for their annual reviews during their birthday month, the benefits to the patients was that they did not need to attend the practice more frequently than necessary for routine care.

The practice performance for 2013 - 2014 in respect of patients with long term conditions was variable; with some being below and some being average for the locality. Data for 2014 - 2015, verified by NHS England but not published showed that the practice had improved.

Summary of findings

Families, children and young people

Requires improvement

The provider was rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice offered clinics for baby immunisations. The data showed that the practice performance was comparable. Multi-disciplinary team meetings were held to help protect children and families where there were safeguarding concerns. The practice offered breast feeding and baby changing facilities. Opportunistic health promotion, including sexual health was offered to teenage patients during their consultation for routine immunisation boosters. A full family planning service was offered with contraception options including long acting methods such as implants. Children that were unwell were offered appointments and could be seen or could have received telephone advice within a two hour time frame.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had signed up to the extended hours enhanced service. Appointments were available on a Wednesday or Thursday evening between 6.30pm and 8.30pm each week, and these could be booked on line. Repeat prescriptions were available to order on line and could be sent directly to the pharmacy of choice.

Smoking cessation and weight management appointments were available. The practice offered NHS Health Checks to patients aged 40 to 75 years.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as inadequate for providing safe services and requires improvements for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had a register of 69 patients with learning disabilities; the practice told us that 81% of these patients had had a review in the past year. Of these patients, 7% had a care plan in place.

The practice employed a health champion who had developed a network with local agencies. Vulnerable patients were able to be

Summary of findings

signposted to these, to be offered extra support. For example, the practice was a distribution centre for food bank vouchers. Food vouchers were given to vulnerable people on low income and who were in a “crisis".

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice told us that 90% of patients on the mental health register had been reviewed in the past 12 months.

The 2013 - 2014 QOF data showed the practice performance in respect to mental health to be 73.8% this was 20.2% below the CCG average and 16.6% below the England average. Data verified by NHS England showed that this improved to 100% for 2014 - 2015.

The practice had employed a community psychiatric nurse to improve the care and outcomes for patients experiencing mental ill health. Home visits were available for patients who could not attend the practice. The practice had a register for those with dementia, QOF data for 2013-2014 showed the practice performance was 87.8% this was 8.3% below the CCG average and 5.6% below the England average. Data verified by NHS England showed this had improved to 100% for 2014 - 2015.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection and three members of the patient participation group. All of the patients told us that they were involved in their care and treatment and were satisfied with the clinical care provided. The patients reported that access to see GPs was difficult, but patients were satisfied with the clinical care they received from the skill mix of advance nurse practitioners and specialist nurses. Patients reported that all staff treated them with kindness, were polite and respectful. Data from the GP Patient Survey from January 2015 indicated the practice performed below the CCG and England averages although the response to the survey was low and only represented about 1.3% of the population.

- 84% of patients said that they found the receptionist helpful compared with the CCG average and national average 87%.
- 88% of patients said the last appointment they got was convenient compared with a CCG average of 91% and a national average 92%.
- 62% of patients said they were satisfied with the surgery opening hours compared with a CCG average of 71% and a national average of 75%.
- 48% of patients said that they found it easy to get through by phone compared with a CCG average of 70% and a national average of 73%.
- 20% of patients with a preferred GP said that they usually get to see or speak to that GP compared with a CCG average of 53% and a national average of 60%.
- 63% of patients said that they were able to get an appointment to see or speak to someone the last time they tried compared with the CCG average of 82% and the national average of 85%.

The practice was aware of these results and had looked at how they configured their staffing to provide more clinical capacity using advanced nurse practitioners. The Patient Participation Group (PPG) members we spoke with told us that the practice was responsive to the issues that were raised, in particular, the shortage, and access to GPs. The PPG supported the new appointment system, but reported that access to GPs was still an issue.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure there are effective systems designed to identify, assess and mitigate against risk, for example in respect of concerns with infection prevention and control.
- Ensure that there are effective systems in place to assess and monitor the quality of the service being provided; for example by ensuring audits of practice are undertaken, including completed clinical audit cycles.
- Ensure processes to deal with clinical letters from other agencies, detailing the changes needed to patient's medications are robust, actioned timely and by the appropriate staff.
- Ensure a system is in place to give oversight ensuring all the required employment checks are carried out for all staff to ensure they are suitable to work with patients.
- Ensure that all staff are trained appropriate to their role and that training records are kept.
- Ensure robust systems are in place to manage and store stocks of medicines to minimise the risk of out of date medicines and dressing being used.
- Strengthen the system that would ensure that learning from significant events, and near misses was recorded, learning shared, and improvements made.

Action the service SHOULD take to improve

In addition the provider should;

Summary of findings

- Ensure that the practice has an approved safeguarding policy implemented.

Blue Dykes Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP specialist advisor. The team also included a practice manager, specialist advisor, expert by experience, and a second CQC Inspector.

Background to Blue Dykes Surgery

Blue Dykes Surgery, provides a range of general medical services to 8693 registered patients living in the area of Clay Cross, Chesterfield.

The partners are registered providers for a second site and this was not included in this inspection.Data shows the practice serves an area where income deprivation affecting children and older people is slighter higher than the England average. Additionally, the area has a higher than average number of patients living with a long term health condition and with health related problems affecting their daily life.

The practice holds a PMS (Personal Medical Services) contract and offers some enhanced services and a range of clinics and services. These include chronic disease clinics, baby immunisations, soft tissue joint injections, and flu injection clinics. The practice is open 8am to 6.30pm Monday to Friday with extended hours to 8.30pm each week either on a Wednesday or Thursday. Appointments with the GPs and advance nurse practitioners are available to book up to two weeks in advance and with the practice nurses up to one month in advance. There are emergency appointments on the day for patients that needed to be seen.

There are GP two partners, one male, and one female who hold financial and managerial responsibility for the practice. They are supported by a salaried GP, a practice employed pharmacist, four advance nurse practitioners (ANPs), one chronic disease nurse, five practice nurses, a community psychiatric nurse, and healthcare assistant. The non-clinical staff comprises a practice manager, an assistant practice manager, care coordinator and there are 18 reception/administration staff.

Derbyshire Health United provides the out of hours cover for the practice.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcome Framework data, this relates to 2013 - 2014, the most recent information available to the CQC at the time. Data used for 2014 - 2015 has been verified by NHS England but had not been published.

Detailed findings

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?

Before the inspection, we reviewed a range of information we held about the practice. We also reviewed information we had received from the service and asked other organisations, including Healthwatch to share what they knew about the service. We carried out an announced visit on 4 August 2015. During our visit we spoke with a range of staff including, GPs, a nurse, a pharmacist, the practice manager, assistant practice manager and reception staff. We spoke with another GP and three nurses on 19 August 2015. We spoke with eight patients who used the practice. We reviewed one comment card where the patient shared their view and experience of the practice. We spoke with three members of the patient participation group (PPG). Four patients had sent positive comments to Healthwatch. We spoke with two local pharmacies that worked with the practice and with one care home manager.

Inadequate

Are services safe?

Our findings

Safe track record

The practice was not able to demonstrate that it had a safe track record over time. The system used for recording, investigation and discussion of incidents at the practice had weaknesses which did not assure us that incidents involving patient safety were regularly reviewed to minimise the risk of them reoccurring in the future. For example, safety alerts received from the Medicines, Healthcare products Regulatory Agency were printed, and staff initialled to indicate that they had read the document. The system did not identify who was responsible for taking any action needed. Staff told us that actions were taken and we saw that the practice did undertake an audit following a safety alert in October 2014.

Learning and improvement from safety incidents

The system used for recording, investigation and discussing significant events at the practice needed to be strengthened. For example, there was poor documentation in respect of the investigation, discussions, and reflection that had been undertaken in respect of a significant event following a home visit and subsequent admission to hospital. The practice was not able to evidence that issues had been discussed and followed up. Although staff told us significant events were discussed at practice meetings, we did not see any minutes that covered detailed discussions around incidents. There was not sufficient assurance that there was an effective system to ensure shared learning across the practice team.

Reliable safety systems and processes including safeguarding

The practice was unable to provide records and / or certificates to evidence that staff had received relevant training on safeguarding. This included confirmation that the GP lead for safeguarding had completed the required level of training for safeguarding children. The practice safeguarding policy had not been approved by the partners and therefore had not been shared with all staff. Most of the staff we spoke with knew how to recognise abuse in older people, vulnerable adults, and children. They were also aware of their responsibilities to report any safeguarding concerns to the safeguarding lead.

Clinical staff were appropriately using the required codes on their electronic patient records system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with the health visitor team. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments. These were brought to the GP's attention, who then worked with other health and social care professionals. We saw medical records that confirmed vulnerable patients were discussed.

There was a chaperone policy, and notices informing patients of this service were displayed in the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and a health care professional during a medical procedure). All staff that performed chaperone duties had received in-house training and Disclosure and Barring Service (DBS) checks. (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).Staff we spoke with knew and understood their responsibilities in the duties of a chaperone.

Medicines management

The arrangements for managing medicines including obtaining, prescribing, recording, handling, storing and security did not always keep patients safe. For example, the system in place for dealing with correspondence from secondary care or other clinics about changes to patients' medicines was not effective.

On the day of our inspection, the practice had a backlog of 124 letters from secondary care providers and clinics. Eighty six of these had been assigned as tasks to the pharmacist but had not been actioned. Many of these tasks were over two weeks old which indicated there were delays in patients receiving amended prescriptions in line with clinical recommendations.

We reviewed the medical records of two of these patients in detail and noted that one of the notifications had been sent to three different staff members, but no action had been taken any of them. In both cases, the medicines for the patients should have been reviewed and changed but

they had not been. One of these medicines was a high risk medicine requiring regular review to ensure correct dosage. The patient had not received medicines that had been prescribed for them in a timely manner.

The practice system for managing changes to repeat medications included a non-clinical person adding new medications to the patient records. The staff member sent a notification to the clinician to check the entry. The system did not prevent staff from issuing this medication before the clinician had approved it.

This was highlighted to the practice on the day of the inspection and they took immediate action to address this issue.

The practice told us that seven clinical staff performed international normalised ratio (INR) testing and dosing. INR is a test performed on a blood sample to measure blood clotting. We asked for evidence to show that staff had received appropriate training and guidance to enable them to undertake this role safely but the staff at the practice were not able to provide us with this. Two nurses we spoke with told us that they had undertaken on line training and an assessment by a colleague who was experienced in the testing and dosing process for INR monitoring.

We observed emergency drugs in the practice were not stored in a lockable room and they were not secure. This was addressed by the practice during the inspection. All other drugs and vaccines were stored safely and the temperature of the fridges used to store medicines had been recorded.

We found expired medical consumables in two different consulting rooms. These were removed during our inspection; but there was not a robust system to check the expiry dates and ensure in date dressings were used.

The pharmacist carried out medication reviews for patients with repeat medication. We saw medical records that confirmed this. The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw PGDs that had been signed by the appropriate nurses. PGDs provide a legal framework that allows nurses to administer a specified medicine(s) to patients, without them having to see a doctor.

Cleanliness and infection control

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse we spoke with confirmed that she was the infection control lead, although she had not been given any training to undertake this role. There were infection control policies in place and these had been reviewed on 22 July 2015. An infection control review had been completed on 29 June 2015 and this identified improvements to be made. These included providing staff training. The practice manager told us training was planned for September 2015. Although the practice had identified the need for training for all staff, no changes had been made to the staff induction plan, as this did not include infection control training specific to individual roles.

The practice had a policy for the management, testing, and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks and remedial action was planned in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments, and treatments. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was May 2015. We saw evidence of calibration of most of the equipment; but a blood pressure monitor had not been checked. We also noted the practice did not have an asset register / inventory of all equipment available to ensure all equipment was tested. The deputy manager informed us they were in the process of compiling this for future use.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The four staff files that we looked at did not contain all of the evidence to demonstrate that appropriate recruitment checks had been undertaken prior to employment. For example, one advance nurse practitioner's (ANP) file did not contain evidence of a DBS check. The practice confirmed after the inspection that this

was in progress. Another contained an out of date certificate for the practice nurse's inclusion to the practice medical defence union (MDU) group scheme. The practice confirmed within 24 hours that all staff were appropriately covered, but the nurse had been practising without this cover. Although the nurse did not have medical defence cover they were covered under the practice insurance.

On the day of the inspection the practice was not able to show us any evidence of GMC (General Medical Council) registration, DBS (Disclosure and Barring), or medical indemnity for locums that were working in the practice. We highlighted this to the practice who took immediate action and following the inspection shared the information.

Patients told us that there was not enough GP staff and that they and to wait a long time to see the GP of their choice.

Monitoring safety and responding to risk

The practice had a health and safety policy and the most recent risk assessment had been completed on 7 May 2015. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had carried out a fire risk assessment on 26 May 2015 that included actions required to maintain fire safety. They had also carried out a fire evacuation test on the 27th July 2015 and there was general guidance given to every member of staff at induction. The practice was unable to provide records to confirm that staff had received fire training but this was planned for 16th September 2015. Staff we spoke to were aware of safety policies and their role and responsibility.

Arrangements to deal with emergencies and major incidents

The practice could not provide records to show that all staff had received training in basic life support. The practice manager confirmed that staff were not up to date with this training and further training had been planned for September 2015. There was no evidence of when training was last undertaken.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of the computer system and other essential supplies. There was a list of contact numbers for staff. The plan was dated 1 August 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence. Staff told us that they regularly used on line learning and that they regularly attended education meetings that were run by the CCG.

There was a wide range of clinical skills within the nursing team. This team included a community psychiatry nurse, chronic disease nurses who saw patients with long term conditions both in the practice and patients' own homes, a practice nurse, and a healthcare assistant. Staff told us they led in specialist clinical areas, which allowed the practice to focus on specific conditions such as diabetes, heart disease, and asthma.

Records reviewed showed the practice identified patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multi-disciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. The practice policy was to contact patients who had recently been discharged from hospital, records reviewed showed that this needed to be strengthened as delays to care and treatment had occurred.

Management, monitoring and improving outcomes for people

The practice showed us five clinical audits (four regarding medication) that had been undertaken in the last two years. An audit undertaken following a Medicines and Healthcare products Regulatory Agency (MHRA) safety update was carried out in October 2014 and recommendations noted that the result would be discussed at a practice meeting.

There was no evidence in the practice meeting minutes that this took place. The audit was repeated in July 2015. The audit results showed that the practice still had patients that could be at risk from the medication prescribed.There was no evidence to show that any outcomes from the audits had been shared or that any improvements had been made and monitored. The practice also used the information they collected for the Quality and Outcome Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices managing some of the most common long term conditions such as diabetes and for the implementation of preventative measures. The data for 2013 - 2014 showed that the practice had performed below the Clinical Commissioning Group (CCG) and national average in a number of areas. However data verified by NHS England but not yet published showed the practice performance had improved for 2014 - 2015. The practice preformation in relation to;

- indicators relating to diabetes improved from 73% to 86%
- indicators relating to dementia improved from 86% to 100%
- indictors relating to hypertension improved from 56% to 100%
- indictors relating to mental health improved from 74% to 100%
- indictors relating to peripheral arterial disease improved from 80% to 97%
- indicators relating to secondary prevention of coronary heart disease improved from 67% to 96%

The nationally published QOF data for April 2013 to March 2014 showed that the practice achieved 82.38% of the total points available. This was below the CCG average of 95.6% and the national average of 94.8%. Data verified by NHS England showed that the practice had increased their score to 95.85% for 2014-2015 The practice had been aware of all the areas where performance for 2013 - 2014 was below the national or CCG figures and action plans were in place to address this. For example the recall system had been improved and patients were invited for their annual reviews in the month of their birthday, and all their long term conditions and medicines were reviewed in one appointment.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The benchmarking data for the period February 2013 to January 2014 showed the practice had outcomes that were comparable to other services.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

The practice manager told us that all staff had received an appraisal in the past 12 months and records we looked at confirmed this. However, the practice could not provide us with evidence that staff had received training which its own policies indicated that staff were expected to attend. There was a staff induction plan which staff confirmed they had attended. There was scope within the induction for staff to consolidate their learning. We saw and the practice manager told us they were in the process of writing an induction pack for locum GPs and locum advance nurse practitioners.

Working with colleagues and other services

The clinical staff we spoke to told us they worked with other service providers to meet patients' needs and manage those patients with complex needs.

We saw that the practice received blood test results, x ray results, and letters including discharge letters from the hospital. We saw that information was scanned onto patient records. The practice told us that non-clinical staff made the decision about which letters to send to the clinical staff. Therefore there was a risk that the GP did not see all relevant patient correspondence.

The practice held meetings with the health visitors to discuss any safeguarding issues. Minutes were not kept of the meetings but we saw evidence that medical records were updated following these discussions.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made all possible referrals last year through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date, and time for their first outpatient appointment in a hospital.

The practice had signed up to the electronic Summary Care Record and this was fully operational. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. Information to opt out of this shared record was available on the web site and in the waiting room. The information needed to plan and deliver care and treatment was available and accessible to relevant staff through the practice's patient record system and their intranet system. This included care plans, medical records, and test results.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, a patient's verbal consent was documented in their electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of any surgical procedure such as soft tissue injections. Additionally written consent was obtained and records we looked at confirmed this. All staff we spoke with were clear about when to obtain written consent. The staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They understood the key parts of the regulations and their duties. Staff were also aware of patients who needed support from nominated carers and clinicians ensured that carers' views were listened to as appropriate.

Health promotion and prevention

The practice displayed a wide range of health promotion and prevention information for the patients. The practice was offering NHS Health Checks to patients aged 40 to 75 years. The practice's performance for the cervical screening programme 2014 to 2015 was 80.6% this was 1.9% above the CCG average of and 1.3% above the national average. The staff told us that they encouraged patients to attend for bowel and breast screening opportunistically. Data from the Cancer Commissioning Toolkit showed that

- Prevalent cancer cases was 2.9%. This was above the CCG average of 2.3% and the national average of 2.1%
- 79.9% of women aged 50 to 70 were screened for breast cancer in the last 36 months. This was above the CCG average of 75.% and national average of 73.2%
- 63.5% of patients aged 60 to 69 had been screened for bowel cancer in the last 30 months. This was above the CCG average of 59.8% and the national average of 58.3%

The practice offered a full range of immunisations for children, travel vaccines, and flu vaccinations in line with current national guidance. Data from 2013 – 2014 showed the practice performance was average for the majority of immunisations where comparative data was available. For example

Good

Are services effective?

(for example, treatment is effective)

Flu vaccination rates for the patients aged over 65 years were 74.5%. This was similar to the national average 73.24%. Flu vaccinations for patients aged over 6 months and under 65 years, and in the clinical at risk groups was 39.9%. This was below the national average of 52.29%.

Practice data for 2014 to 2015 showed the immunisations rates for patients over 65 years were 73.25% and for patients aged 6 months and 65 years in the clinical at risk groups was 66.25%.

Childhood immunisation rates for vaccinations given to under twos was over 90%. This was comparable to CCG/ National averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and people were treated with dignity and respect. Eight patients we spoke to told us that all the staff were friendly and helpful. Patients appreciated that staff called them by their names and that clinical staff collected them from the waiting room and held doors open for them to go through. We received one completed comment card and this was positive about the service experienced.

Patients' confidentiality was respected when care was being delivered and during discussions with staff. For example, consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in consultation rooms so that patient's privacy and dignity was maintained during examinations, investigations, and treatments. We noted that consultation room doors were closed during consultations and these conversations could not be overheard.

Reception staff understood what to do when patients wanted to discuss sensitive issues or appeared distressed and confirmed they could offer patients a private room to discuss their needs. The area where the telephones were answered had privacy screens which enabled staff to answer the calls away from patients therefore reducing the risk of being overheard.

The results from the national GP patient survey published in July 2015 showed that most patients were happy with how they were treated and that this was with compassion, dignity, and respect. The practice was similar to national and local averages for most of its satisfaction scores on consultations with doctors and nurses. For example:

- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%.
- 96% of patients said they had confidence and trust in the last nurse they saw compared to the CCG and national averages of 97%.
- 87% of patients said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 93% of patients said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 74% of patients said the GP gave them enough time compared to the CCG average of 83% and national average of 87%.
- 91% of patients said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.
- 84% of patients said they found the receptionists at the practice helpful compared to the CCG and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke to 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 had received. They also told us 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.Results from the national GP patient survey we reviewed showed a variable response from patients in respect of questions about their involvement in planning and making decisions about their care and treatment. For example:

- 81% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 70% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%
- In relation to nurses:
- 93% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 91%.
- 85% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had experienced significant GP shortages in 2013 and responded to this need by employing a wider skill mix of specialist nurses to ensure the most appropriate patient care. This included:

- A community psychiatrist nurse to assess and support patients experiencing mental ill health. Patients could be seen on the same day and staff told us that this had a positive effect for patients.
- Four advance nurse practitioners (ANPs) to undertake clinical assessment make a diagnosis and arrange treatment. Patients were able to choose to see a male or female advance nurse practitioner.
- A chronic disease nurse to review patients with long term conditions.
- A pharmacist to see and or manage patients for medication reviews and to manage the practice's prescribing polices.

The total number of clinical sessions that were available for each week was,

- 18 GP sessions
- 19 advance nurse practitioners sessions, with an additional five sessions for visiting patients in their own homes
- 10 community psychiatric nurse sessions
- Eight chronic disease nurse sessions for visiting patients in their own homes
- Three pharmacist sessions

The practice used locum GPs and locum advance nurse practitioners if the usual clinicians were unavailable. The medicines management team within the CCG supported the practice with an additional pharmacist for one session per week. This pharmacist undertook medication reviews for patients during their session.

The practice showed us CCG benchmarking data from February 2013 to January 2014 that showed patients from the practice were better than the CCG average for attendance at Accident and emergency and walk in centres.

Tackling inequity and promoting equality

The practice was accessible for patients with mobility needs and those using hearing aids. This included disabled parking and toilet facilities, wheel chair access, automatic doors, handrail, and a hearing loop. Baby changing facilities were also available. Staff told us that translation services were available for patients whose first language was not English.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday; appointments were from 8.30am to 6.00pm each day. The practice offered extended hours on either a Wednesday or Thursday each, appointments were available until 8.30pm Information was available to patients about appointments on the website and in the practice leaflet. There were also arrangements to ensure patients received urgent medical care assistance when the practice was closed. The practice had introduced a new appointment system from April 2015. This entailed 50% of the appointments being pre bookable up to 2 weeks in advance, and 50% of the appointments being available on the day. The practice offered a minimum of four clinical sessions each morning and afternoon. These sessions included appointments with GPs, advance nurse practitioners, the community psychiatric nurse, and a pharmacist. The chronic disease nurse visited patients in their own homes.

We looked at the national GP patient survey data, published in July 2015. Two hundred and sixty-eight (268) surveys were sent out; with 114 surveys returned. This was a 43% completion rate but represented only 1.3% of the practice population. The results were significantly below local and national averages in respect of access to the service, appointments, and waiting times to be seen. For example:

- 46% of patients who responded described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73%.
- 48% said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 57% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.
- 62% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 41% felt they didn't normally have to wait too long to be seen compared to the CCG average of 56% and national average of 58%.

Patient feedback we received and data reviewed showed continuity of care was also an issue of concern. For example, national patient survey data showed only 20% of patients usually got to see or speak to their preferred GP compared to a CCG average of 53% and national average of 60%.

The management team was aware of the low national satisfaction rates and had implemented a new model of care in response to GP shortages. The practice was looking to improve patient awareness of the new system. The practice manager told us a 'sit and wait' service was offered to meet demand for appointments. Patients who attended this service were seen in order of priority / arrival time. This service was offered at the end of each morning. Patients told us this was useful as they were seen on the day if they needed. Patients were offered a telephone call with the duty doctor if they preferred.

In December 2014, the practice undertook a survey around changes it had made to access. Two hundred and fifty (250) questionnaires were handed out to patients who attended the practice; there was a 100% return rate.

Results from the survey showed,

92.1% of patients who had used the triage system were satisfied with the service.

87.5% of patients who had seen an advance nurse practice were satisfied with the service.

63.9% of patients who had used the services of the pharmacist were satisfied with the service.

Home visits were undertaken for those patients who were unable or too unwell to attend the practice. The advance nurse practitioners usually undertook these visits although patients with end of life / palliative care needs were visited by the GPs.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns which was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. Information was available to help patients understand the complaints system. This included posters displayed in the waiting area and a summary leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The patient participation group (PPG) members that we spoke with told us patients were able to report their complaints to them. The members felt the practice had dealt with all the complaints shared with them in an appropriate manner. The patient participation group is a group of patients who work together with the practice staff to represent the interests and views of patients to improve the service provided to them. We looked at 12 complaints received in the last 12 months and found these were satisfactorily handled and an appropriate response was provided to the patient. Records reviewed showed the complaints were discussed at the practice meetings.

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 practice had a vision and clear strategy. The goals were clear and the staff we spoke with all shared the same vision to care for patients. Our inspection findings showed this vision was not always achieved due a lack of effective and comprehensive processes to assess, monitor, and improve the quality and safety of services provided. Although the two GP partners covered two sites, a mixture of GP, advance nurse practitioners and regular locum GP, provided the cover at the second site. The practice was trying to meet demand and increase clinical capacity through the development of its new model of care. The partners acknowledged that focussing on access issues had restricted their ability to manage systems and monitor services to ensure effectiveness. The practice leadership acknowledged this was an area for improvement. They had prioritised addressing their immediate challenge of GP shortages and were actively recruiting for a full time GP.

Governance arrangements

The overarching governance framework was not robust. The systems in place were not operating effectively and did not enable the provider to have a clear oversight of the quality of the service and the risks to the health and welfare of patients and others. For example:

- Although there was a clear staffing structure and staff were aware of their own roles and responsibilities, they told us that, at times, they were uncertain of leadership responsibilities. For example, staff told us they were not always certain who was responsible when things did not go well.
- Practice specific policies were not always made available to all staff or implemented. For example, a new safeguarding policy had been written but had not been approved. There was no evidence of a previous version.
- Arrangements for identifying, recording, and managing risks, issues, and implementing mitigating actions needed to be strengthened to ensure they were robust and protected patients and others against risks to their health and welfare. For example, we found that non-clinical staff were adding new medications to patient records. There was a risk that these medicines could be issued to a patient before a clinician had checked and approved them.
- The workload of staff members was not monitored to prevent delays in patients receiving care and treatment. For example delays in patients receiving medicines requested by secondary care.
- The systems needed to be strengthened to ensure that training, recruitment checks, and equipment checks were managed to keep patients and staff safe. For example, the infection control lead had not been trained to undertake this role.
- There was no system to ensure that stock control was managed. For example out of date dressings were found.
- The system that would ensure that learning from significant events, and near misses was recorded, learning shared, and improvements made needed to be strengthened.
- Audits were not used to identify and drive improvements.

Leadership, openness, and transparency

The staff we spoke with told us that an open and transparent culture was promoted within the practice and they had the opportunity to raise any issues at team meetings. Staff gave examples of how they had worked together as a team to address the staffing challenges and adapt to a new way of working. Key phrases used by staff included: collective responsibility; collaborative team approach, and a flat culture where every staff member's view was considered.

Seeking and acting on feedback from patients, public and staff

The practice had an active working relationship with the patient participation group (PPG). The PPG members we spoke with felt the practice listened to them and they felt valued. The PPG meeting minutes that we looked at showed the practice had implemented a number of changes following patient feedback. These included

Are services well-led?

Requires improvement

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

changes to the appointment system and availability of on line booking for appointments. The PPG also undertook fundraising activities and had raised money to purchase a cold water machine in the waiting room.

The practice gathered feedback from staff through staff meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run, for example the non-clinical staff had been involved in the design of the new appointment system ensuring that it was a system that worked for reception staff as well as clinical staff.

Management lead through learning and improvement

The partners encouraged a culture of teamwork and when we spoke with staff, without exception they told us that they valued this. Staff told us that regular team meetings were held and that there was an open culture within the practice, they had the opportunity to raise any issues at team meetings, and confident in doing so and felt supported if they did. However, the detail of the discussion, actions, and learning was missing from the minutes and there was no evidence that learning was shared throughout the practice. The practice did not have sufficient leadership capacity to ensure that there were effective systems in place for governance and oversight of the quality of the service. There were a number of areas where the absence of effective systems did not provide partners with the oversight needed to assure them that their service was delivering safe patient care.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation** Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessing the risks to the health and safety of service users of receiving the care or treatment; ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; • The practice did not have an infection prevention lead that had received the required training. The staff had not received infection prevention training. • The practice did not have evidence that staff were trained and up to date in basic life support. Regulation 12 2(c) The registered person must provide safe care and treatment for service users. Assessing the risks to health and safety of service users of receiving the care or treatment.Doing all that is reasonably practicable to mitigate any such risks. • The practice did not have a robust system to ensure that the medications of patients were actioned timely and a system that ensured delays in changes to patients medication requested by other agencies was prevented. Regulation 12 2(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Such systems or processes must enable the registered person, in particular to-

Assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity (including the quality of the experience of service in receiving those services);

Assess, monitor, and mitigate the risks relating to health, safety, and welfare of service users and others who may be at risk which arise from the carrying out of a regulated activity.

maintain securely such other records as necessary in relation to

Persons employed in the carrying out of the regulated activity andthe management of the regulated activity;

evaluate and improve their practice in respect of the information referred to above;

- The practice did not have a robust system to ensure that significant events were discussed and that learning was shared with the practice
- The practice did not have robust systems and audits to evaluate their services to ensure they were delivering an effective service.
- The practice did not have a robust system to ensure that the workload of the staff was monitored and managed to ensure patient safety.
- The practice did not have a system to ensure safe stock control that ensured that up to date medicines and dressings were used.
- The practice did not have a robust system that ensured all staff employment checks were in place and recorded.

Regulation 17 (2)(a)(b)(d)(f)