Willow Bank Partnership Community Interest Company

Quality Report

Willow Bank Health Centre
Trentham Road
Longton
Stoke on Trent
Staffordshire
ST3 4SJ
Tel: 0300 123 1467
Website: www.willowbankcic.org

Date of inspection visit: 21 June 2017
Date of publication: 06/07/2017

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

Ratings

Overall rating for this service	Good
Are services safe?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Willow Bank Partnership Community Interest Company (also known as Willow Bank Health Centre) on 4 August 2016. The overall rating for the practice was Good with requires improvement in providing safe services. The full comprehensive report from the 4 August 2016 inspection can be found by selecting the 'all reports' link for Willow Bank Partnerships Interest Company (Willow Bank Health Centre) on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 21 June 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breach in regulation that we identified in our previous inspection on 4 August 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as Good.

Our key findings were as follows:

- The provider had enhanced their systems to receive and act on alerts about medicines that may affect patients' safety.
- A written policy had been introduced for the identification and process of handling significant events.
- A process had been introduced for regularly reviewing Patient Group Directions (PGDs) to ensure that they met legislative requirements.
- The provider had not improved the monitoring of practice infection control compliance in-between audit cycles.

We also saw the following best practice recommendations we previously made in relation to providing effective, caring and responsive services had been actioned:

- The provider had prioritised a plan and was working towards improving the uptake of annual health assessments for patients with a learning disability. Sixty percent of assessments had been completed since the last inspection and the remainder were scheduled to take place.

Summary of findings

- The provider had carried out a detailed audit to investigate the reasons for the higher than average attendance at A&E by registered patients and was following up frequent attenders, reviewing and discussing ways that they can be supported.
- The provider had reviewed the reasons for lower patient satisfaction in the GP national survey for patient experience of their interaction with GPs.

However, there were still areas of practice where the provider could make improvements.

The provider should:

- Develop a more detailed significant event reporting template and undertaking a regular analysis of significant events to identify trends and monitor the effectiveness of any changes made.
- Improve the monitoring and documentation of infection control across the practice.

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?

Good

The practice is rated as good for providing safe services.

- The provider had enhanced their systems to receive and act on alerts about medicines that may affect patients' safety.
- A written policy had been introduced for the identification and process of handling significant events.
- A process had been introduced for regularly reviewing Patient Group Directions (PGDs) to ensure that they met legislative requirements.
- The provider did not have a documented process in place for the monitoring of practice infection control compliance in-between audit cycles.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Develop a more detailed significant event reporting template and undertaking a regular analysis of significant events to identify trends and monitor the effectiveness of any changes made.
- Improve the monitoring and documentation of infection control across the practice.

Willow Bank Partnership Community Interest Company

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor.

Background to Willow Bank Partnership Community Interest Company

Willow Bank Partnership Community Interest Company operates a General Practice from Meir Primary Care Centre in Stoke on Trent. The company is owned by the staff with a board of Directors and holds an Alternative Medical Provider Services contract with NHS England. Willow Bank operates two GP practices within Stoke on Trent:

- Willow Bank Health Centre, Longton.
- Willow Bank Surgery, based within Meir Primary Care Centre.

Patients can use either site and are recorded as having a preferred practice. Each practice is currently registered with the Care Quality Commission separately. We visited both practices as part of our inspection. This report relates to our findings at Willow Bank Surgery, based within Meir Primary Care Centre. The provider has very recently submitted an application to remove the Willow Bank Health Centre registration and operate the practice as a branch location under the Willow Bank Surgery registration.

There are a total of 10,750 patients registered of which 4,075 give their preferred practice as Willow Bank Health Centre in Longton, although patients can be seen at either location. The practice population is not similar to the national average as it contains more patients aged 39 and under and less patients aged 50 and over. Deprivation in the locality is higher than both the clinical commissioning group (CCG) and national averages.

The opening hours at Willow Bank Health Centre, Longton are:

- Monday, Wednesday and Friday 8am to 6pm.
- Tuesday 8am to 12.30pm and 2pm to 6pm.
- Thursday 8am to 5pm.

Patients can access Willow Bank Surgery, based within Meir Primary Care Centre where the opening hours are:

- Monday to Friday 8am to 8pm.
- Saturday 8am to 4pm.
- Sunday 10am to 2pm.

Staff work across both sites and include:

- Staff work across both sites and include:
- Nine GPs (six female, three male)

Detailed findings

- Seven female registered nurses of which five work in extended and/or independent prescribing roles.
- Three female healthcare assistants.
- One practice clinical pharmacist.
- A management administrative and reception team of 22 staff led by the managing director assisted by a customer services manager.

Why we carried out this inspection

We previously undertook a comprehensive inspection of Willow Bank Partnership Community Interest Company (also known as Willow Bank Health Centre) in Longton on 4 August 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall with requires improvement for providing safe services. The full comprehensive report following the inspection on 4 August 2016 can be found by selecting the 'all reports' link for Willow Bank Partnership Community Interest Company (Willow Bank Health Centre) on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Willow Bank Partnership Community Interest Company (Willow Bank Health Centre) on 21 June 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced focused inspection on 21 June 2017. During our inspection we:

- Spoke with a range of staff including one GP, the practice clinical pharmacist, two practice nurses, four receptionists, the customer service manager and the registered manager/managing director.
- Spoke with two patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed the arrangements for acting on alerts about medicines that may affect patients' safety.
- Reviewed the written policy for the identification and process of handling significant events and the process for regularly reviewing Patient Group Directions (PGDs).
- Reviewed protocols, complaints documentation, A&E attendance figures, the uptake of annual learning disability assessments and GP national patient survey data.
- Looked at information the practice used to deliver care and treatment.

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.

Good

Are services safe?

Our findings

At our previous inspection on 4 August 2016, we rated the practice as requires improvement for providing safe services. This was because:

- The provider did not operate an effective system to receive and take appropriate action on alerts issued by the Medicines and Healthcare Regulatory Agency about medicines.
- The provider did not have a written policy for the identification and process of handling significant events.
- The provider did not have a process for regularly reviewing Patient Group Directions (PGDs) to ensure that they met legislative requirements.
- The provider did not have a process in place for the monitoring of practice infection control compliance in-between audit cycles.

The majority of these arrangements had improved when we undertook a follow up inspection on 21 June 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

At the previous inspection we found the process for acting on medicine alerts that may affect patient safety was not fully effective. Staff told us they received information, disseminated it and took action when needed. We looked at what action the practice had taken in relation to recent medicines alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Staff told us they had not received any of the recent alerts that we looked at. Shortly after our inspection the practice identified that their subscription to the MHRA did not include drug safety updates which included medicines alerts. The practice took action by updating their subscription and had begun an audit to establish if any actions were required on past alerts.

During this inspection we saw the practice had enhanced their systems for obtaining and recording external alerts that may affect patients' safety. The practice clinical pharmacist had been given lead responsibility for MHRA alerts. We saw a log of all alerts received had been maintained and the practice checked whether patients were affected by the medicines or equipment involved. Records detailed the action taken in response to each alert and these were discussed at the majority of clinical meetings held. The provider confirmed they would carry out searches on previous alerts received on a regular basis to identify patients that may be at risk associated with the alerts.

At the previous inspection we found there was a system in place for reporting and recording significant events but there was no overall policy for determining a significant event and actions to take following an occurrence. During this inspection we saw the provider had developed an overall policy in addition to a spreadsheet for recording significant events. Staff spoken with confirmed the policy had been shared with them and discussions demonstrated they were aware of the reporting and recording procedures. We saw significant events were a standard agenda item for discussion during clinical and team meetings. We found the significant event reporting template could be improved to include actions required, staff responsible and sign off date in addition to undertaking a regular analysis of significant events to identify trends and monitor the effectiveness of any changes made.

At the previous inspection we reviewed the Patient Group Directions (PGDs) used by practice nurses who were not independent prescribers. The documents had not been fully completed in line with legislative requirements in that they had not been authorised by a senior named doctor at the practice. The provider told us this had been an administrative issue however, following the inspection the practice nurse had been made the lead for ensuring all PGD's were up to date and signed by all relevant staff at each location. We saw evidence of this during this inspection.

Overview of safety systems and processes

At the previous inspection we saw the provider audited infection prevention and control (IPC) measures in place on a six monthly basis. Although we found the practice visibly clean we saw that two of the clinical rooms we reviewed were cluttered and had examples of poor IPC practice. During this inspection we found the practice visibly clean and tidy, however we found similar concerns that we had previously identified. For example, cluttered window sills and desks in clinical rooms as well as two sharps boxes not labelled or dated. A new contractor was providing cleaning services and all of the staff we spoke with told us the cleanliness of the practice had considerably improved. We met with the lead nurse responsible for infection

Good

Are services safe?

prevention and control. During the inspection they scheduled an audit to take place shortly. Although they advised they were monitoring infection control in-between audit cycles they were not maintaining records and they were unable to locate the cleaning schedule for the practice.