Lyme Regis Medical Centre

Quality Report

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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?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 Lyme Regis Medical Centre on 5 August 2015; this was followed up by an unannounced inspection of the practice's minor injuries unit on the evening of 10 August 2015. Overall the practice is rated as requires improvement.

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

- The practice provided standard General Practice services as well as a walk in Minor Injuries Unit run and staffed by the practice nurses. We found this Minor Injuries service was not safe and patients were at risk of harm because systems and processes were not in place to keep them safe.
- We have been in discussion with the practice to make immediate improvements. Actions have been taken to address staffing and skills and a review is underway of the services of the Minor Injuries Unit with NHS England as a result of our inspection.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed, with the exception of those relating to the Minor Injuries Unit.
- There was insufficient assurance to demonstrate people received effective care and treatment in the practice's minor injuries unit.
- Data showed patient outcomes were comparable to other practices in the locality.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Urgent appointments were available on the day they were requested. However patients said that they had seen a number of different GPs or locum GPs and felt continuity of care was not always possible.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the practice management and by the wider organisation. The practice proactively sought feedback from staff and patients, which it acted on. There was a planned programme of meetings involving all staff members and staff groups.
- The practice provided advice on sexual health to young people from the local school. This service was offered without an appointment to young people registered with the practice or neighbouring practices. There was no school nurse in post and so the practice could not demonstrate the positive impact of this as it was unclear how young people were made aware of this service.

We saw areas of outstanding practice:

- The practice had developed a 'Better Balance' programme to support people who were at risk of or who had experienced a fall. This was a 10 week exercise programme, run by a health care assistant and supported by the occupational therapist. The programme consisted of: exercises to improve balance; educational sessions such as diet and fluid advice; visits from the sight and hearing team; falls prevention and a visit from a the practice social worker to explain social support and benefits.

The areas where the provider must make improvements are:

- Ensure staff in the Minor Injuries Unit have appropriate access to clinical guidance to carry out their roles in a safe and effective manner, which is reflective of current best practice.
- Ensure the Minor Injuries Unit only offers treatment according to the training and skills of the staff on duty.
- Ensure a review of training for all staff at the practice appropriate to their role and ensure any further training needed is delivered.
- Ensure that governance arrangements are robust and include an assessment of risks and patient outcomes associated with the provision of the minor injuries unit.
- Ensure the plan of audits includes the completion of clinical audit cycles.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Information suggested that patients had received safe care but this was not as a result of standardised safe systems and processes and the practice could not demonstrate consistency and reliability of safe care to prevent patients being at risk of harm.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements must be made. Although staff throughout the service had knowledge of and referred to national guidelines information showed that care and treatment may not be delivered in line with the guidelines. This was because staff working in the minor injuries unit had not received appropriate up to date training to safely assess, monitor and treat patients with conditions that are listed on the practice web site. There was evidence of clinical audit and changes to practice that had been made to improve outcomes for patients. However the cycles had not been completed in order to demonstrate audit had improved patient outcomes. Multidisciplinary working was taking place and community services worked collaboratively with the GP practice. There were planned programme of formal meetings with detailed records maintained.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly for several aspects of care. Patients said 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, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Although the practice had reviewed the needs of its local population to ensure practice and community services met the needs of their patients this review had failed to ensure that the services listed as available could be met at all stated times. It had a plan to secure improvements in staffing levels and staff mix to meet patients' needs but this had not included the Minor Injuries

Summary of findings

Unit. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Feedback from patients reported that access to a named GP and continuity of care was not always available quickly although urgent appointments were available the same day.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. There were systems in place to monitor and improve quality and identify risk, however the systems had not been effective in identifying the risks to staff and patients in the operation of the minor injuries unit.

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management and the wider organisation. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. There was support provided to older people, through the community service provided by the practice, in patients' own homes. There were regular virtual ward rounds and multi-disciplinary meetings to discuss and manage the care of those with enhanced needs. The practice had developed a better balance group to support patients who may be at risk of falls.

People with long term conditions

Requires improvement

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

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals both from their own community service and other organisations to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

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

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Children and babies were prioritised for urgent appointments. Health visitors on site and school nurses meant that communication was good to ensure that

Summary of findings

the health and wellbeing of families. We saw good examples of joint working with midwives, health visitors and school nurses, however at the time of our inspection there was no school nurse in post and their role was being covered by the health visitors.

The practice saw young people without an appointment for sexual health advice.

Working age people (including those recently retired and students)

Requires improvement

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible appointments were available including telephone consultations and late evening appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

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

The practice did not have a high number of patients with a learning disability these patients had all received an annual health check. It offered longer appointments for people with a learning disability.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

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

One hundred percent of those patients experiencing severe mental ill health had a care plan recorded. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

There were two community psychiatric nurses employed by the practice's community service. One nurse supported those under 65 and the other those patients over 65. Although there was a waiting list for their service they could evidence immediate action had been taken to support people in crisis. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing below local and national averages in a number areas relating to the availability of appointments with patients' GP of choice. There were 260 forms distributed and 113 responses received which was a response rate of 43.5%.

- 91.1% find it easy to get through to this practice by phone compared with a CCG average of 85.3% and a national average of 74.4%.
- 85.9% find the receptionists at this practice were helpful compared with a CCG average of 89.8% and a national average of 86.9%.
- 44.2% with a preferred GP usually get to see or speak with their preferred GP compared with a CCG average of 70.9% and a national average of 60.5%.
- 85.1% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 89.7% and a national average of 85.4%.
- 81.1% say the last appointment they got was convenient compared with a CCG average of 77.8% and a national average of 73.8%.
- 73.7% describe their experience of making an appointment as good compared with a CCG average of 82.3% and a national average of 73.8%.
- 62.1% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 68.3% and a national average of 65.2%.
- 48.4% feel they don't normally have to wait too long in the waiting room to be seen compared with a CCG average of 63.5% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received five comment cards and spoke with two members of the Patient Participation Group (PPG). We also spoke with 21 patients who were waiting for appointments that day. Comments received were broadly in line with the data from the GP survey. Patients praised the care and treatment they received from the GPs and nurses but were unhappy at the lack of continuity due to a number of changes in GPs and GP sickness.

We did not get any feedback from patients receiving community services from the wider practice team.

Areas for improvement

Action the service MUST take to improve

- Ensure staff in the Minor Injuries Unit have appropriate clinical guidance to carry out their roles in a safe and effective manner which is reflective of current best practice.
- Ensure the Minor Injuries Unit only offers treatment according to the training and skills of the staff on duty.
- Ensure a review of training for all staff at the practice appropriate to their role and ensure any further training needed is delivered.
- Ensure that governance arrangements are robust and include an assessment of risks and patient outcomes associated with the provision of the minor injuries unit.
- Ensure the plan of audits includes the completion of clinical audit cycles.

Outstanding practice

- The practice had developed a 'Better Balance' programme to support people who were at risk of or who had experienced a fall. This was a 10 week exercise programme, run by a health care assistant and supported by the occupational therapist. The programme consisted of: exercises to improve balance; educational sessions such as diet and fluid advice; visits from the sight and hearing team; falls prevention and a visit from a the practice social worker to explain social support and benefits.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist advisor in practice management, two further CQC Inspectors and an Expert by Experience. Experts by Experience are members of the inspection team who have experienced care or treatment from a similar service.

Background to Lyme Regis Medical Centre

Lyme Regis Medical Centre is located in Uplyme Road, Lyme Regis, Dorset DT7 3LS. The practice is operated by VH Doctors Limited which is part of the Virgin Care organisation. Lyme Regis is a coastal town in West Dorset popular with holiday makers. The practice provides services to approximately 4,500 patients and is contracted by NHS England to provide community services to 8,500 patients in the locality under an Alternative Provider Medical Services (APMS) contract. (An APMS contract is a contract for primary medical services to provide services within their area to the extent that the commissioners consider necessary to meet all reasonable requirements of the local population).The practice is also contracted by NHS England to provide a nurse led minor injuries unit open to practice patients, patients from other practices and any visitors to the area.

Lyme Regis Medical Centre is part of the Dorset Clinical Commissioning Group. At this inspection we inspected the services provided by the GP practice and the community services.

The practice has four female salaried GPs. The GPs in total provide the equivalent of 3.2 full time GPs. The practice had recently recruited a male GP who was shortly due to start working at the practice and as an interim measure had ensured a male locum GP was available as often as possible.

Support is also provided by an advanced nurse practitioner, five practice nurses, two of whom are non-medical prescribers, and two health care assistants. The practice is further supported by reception and administrative staff. Community services include: community nursing, health visiting, a school nurse, social worker, community mental health nurses, physiotherapists, an occupational therapist, a podiatrist and the provision of a minor injuries unit. The GP practice and community services provided by Lyme Regis Medical Centre are provided by a total of 48 members of staff equivalent to 39 whole time equivalent staff. The services are managed by a service manager and two assistant service managers.

The GP practice is open Monday to Friday 8am to 6.30pm with extended hours on a Tuesday when booked GP appointments are available until 7.30pm and also on Thursdays with nurse practitioner appointments available until 7.30pm. The nurse led Minor Injuries Unit is open between 8am and 8pm Monday to Friday and 8am to 1pm Saturday, Sunday and bank holidays.

The website and practice leaflet states that the nurse led minor injuries unit will see adults and children over the age of one if they have a minor injury or emergency including:

- bites and stings;
- cuts and grazes;
- emergency contraception;
- limb injuries;
- minor burns/scalds;
- minor ear problems;
- minor eye injuries;

- minor foot, knee, hand, elbow and shoulder injuries;
- minor head injuries
- nose bleeds
- removal of foreign bodies from the ears and nose;
- removal of splinters and fish hooks;
- skin infections;
- sprains and strains
- sudden neck pain; and
- suspected fractures/broken bones;
- urinary tract infections; and
- wound care

The GPs at this practice have opted out of providing out of hours services to their patients. When the practice is closed out of hours care and treatment is provided by South West Ambulance Service and can be accessed through the NHS 111 telephone number.

Practice data shows that 58% of the practice population is over the age of 55 and 3% of the practice population is under the age of five years.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

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 and asked other organisations to share what they knew. We carried out an announced visit on 5 August 2015 and an unannounced inspection on 10 August 2015.

During our visit we spoke with a range of staff from the GP practice and from community services. Staff included a GP, nurse practitioner, community nurses, health visitors, community mental health nurses and practice nurses who worked at the practice, including the nurse led minor injuries unit. We also spoke with administration and reception staff, the service manager and their two assistant service managers.

We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely response and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and all staff we spoke with were aware of the system of recording these on the practice's computer system. All complaints received by the practice were entered onto the system which was linked to the provider organisation. The practice carried out an analysis of the significant events. These were also shared with the provider organisation to identify trends and themes.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a complaint was received regarding the catheter care for a patient in the community. This had been discussed with the community team and the standard operating procedure for catheter care was reviewed alongside the pathway of care. Qualified nurses were now sent out to any patient with catheter problems or where there had been one unsuccessful attempt to resolve the problem by a health care assistant.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. Nurses in the Minor Injuries Unit (MIU) had limited access to printed treatment algorithms but these were in place for the management of anaphylaxis and resuscitation and told us they accessed NICE guidance electronically. (An algorithm is a step-by-step set of instructions or actions to be performed)

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements to safeguard adults and children from abuse that reflected relevant legislation. Local requirements and policies were accessible to all staff on Sharepoint the provider's shared electronic system. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible however health visitors and community staff regularly attended. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy and the practice had completed a health and safety work activities risk assessment to monitor safety, such as control of substances hazardous to health, infection control and equipment. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. One of the practice nurses along with an assistant service manager provided lead roles in infection control. They liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

We saw that some of the equipment available to staff in the MIU, such as a manual resuscitator, (tourniquet (a band used to restrict blood flow and part of the equipment used during the process for obtaining blood samples) these objects were not single use and not kept in sterile packaging. Not all staff were aware of recent guidelines regarding the use of personal protective equipment whilst taking blood samples although guidelines were in place for staff.

- Prescription pads were securely stored and there were systems in place to monitor their use. There were

arrangements in place for managing medicines, (obtaining, prescribing, recording, handling, storing and security) including emergency drugs and vaccinations. We found there were no patient group directions (PGDs) in place for nurses to administer medicines or vaccines. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) However we were told that all medicines and vaccines were administered under patient specific direction (PSD) or by a nurse prescriber. (PSDs are written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency to be supplied or administered to a named patient. This is only after the prescriber has assessed the patient on an individual basis.) Medicines could not be provided for patients out of normal surgery hours when the nurse on duty was not a nurse prescriber. We raised our concerns with the provider and received assurance after the inspection that until such time as PGDs were in place or staff received appropriate qualifications in order to prescribe there would be a doctor or prescriber on the premises at all times. A standard operating procedure was put in place immediately after the inspection for the administration of homely remedies such as paracetamol. At the time of our unannounced inspection the practice had put PGDs in place for the administration of some medicines.

Regular medication audits were carried out with the support of the local CCG pharmacy team and also with the provider organisation's lead pharmacist to ensure the practice were prescribing in line with best practice guidelines for safe prescribing, storage and administration of medicines. The most recent audit by the provider in November 2014 had a summary of actions with implementation dates. The practice had completed all the actions to the required timeline. The audit had not identified the risk to patients of the lack of a qualified prescriber on the premises at all times when the MIU was open. The audit had identified the use of remote prescribing where a medicine may be administered on a verbal order in advance of a PSD. The pharmacist had recorded that this should be in exceptional circumstances and not a routine practice. The action to write a new standard operating policy for those exceptional circumstances was due for action by September 2015. At our unannounced inspection staff were very clear that remote prescribing was in emergency cases only.

- Recruitment checks were carried out and the files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice used a workforce planning tool to review the community nurse caseload and a workforce profile tool to ensure workforce requirements were planed according to need. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice had recently employed locum GPs due to staff changes and illness. We saw that future locum cover had been sourced in advance.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use, however the record of checks of the emergency equipment and medicines was not complete.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. One of the nurses in the Minor Injuries Unit (MIU) told us they accessed NICE guidelines electronically. Other nurses were not aware of specific treatments needed for certain conditions and would look these up on the internet if necessary. Staff were not supported in the assessment of patients in the MIU by up to date guidance. There were no readily available, treatment algorithms or guidance for the management urgent conditions, we saw that printed guidelines available for head injury were dated 2003 and a chest pain protocol had been written in May 2011 and had a date for expiry in 2013.

It was the responsibility of staff to ensure they kept up to date with current practice. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed by peer review of patient consultations and the sampling of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 96.7% of the total number of points available with 8.6% exception reporting, the exception reporting for the CCG was 11.1% and nationally was 7.9%. Exception reporting is the percentage of patients who would normally be monitored. These patients are excluded from the QOF percentages as they have either declined to participate in a review, or there are specific clinical reasons why they cannot be included. This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2014 to March 2015 showed;

- Performance for diabetes related indicators was better (100%) than the CCG (95.6%) and national average (90.1%)
- The percentage of patients with hypertension related indicators was better (100%) than the CCG (92.4%) and national average (88.4%).
- Performance for mental health related indicators was better (100%) than to the CCG (95.9%) and national average (90.4%).
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was (92.73%) which was better than the than the CCG average (85.63%) and the national average (83.82%)

Some clinical audits were carried out to demonstrate quality improvement and staff were involved to improve care and treatment and patient outcomes. Topics that could contribute to audits are a standing item on the Governance Team Action log and Nurse meeting minutes. Also the practice audit plan for 2014/15 was referred to in the practice presentation for the inspection. However there was not an established system of audit cycles. Whilst we found there had been a number of clinical audits undertaken in the last two years, we noted that the only completed audit cycles were those for infection control, hand hygiene and the on-going auditing of medicines management.

Improvements had been implemented following the first cycle of audit and many aspects of the practice continued to be monitored. For example, the practice had as part of their Gold Standards Framework audited the preferred place of death for those patients receiving palliative care. They found that this was not routinely recorded. The practice had discussed this and highlighted the need to capture this information. The clinical lead GP acknowledged that this was due for re audit to ensure this information had been recorded for all patients and whether patients' chosen place of death had been achieved.

The practice participated in local audits, national benchmarking and peer review. Findings were used by the practice to improve services. There was a system for the peer review of referrals to ensure they were appropriate. The clinical lead reviewed locum GP consultations and reviewed the patient records written by locum GPs. However we found that this system of review did not take place for other staff groups. For example there was no review of the patient records kept by community staff such as health visitors.

Inadequate

Are services effective?

(for example, treatment is effective)

We saw in the minutes of clinicians' meetings that information about patients' outcomes was used to make improvements to their care and treatment; for example the practice had identified patients that were taking a certain medicine for leg cramps this medicine could potentially have serious side effects. The practice contacted each patient on that medicine to discuss their on-going need for it, discuss alternatives or offer a consultation.

Effective staffing

Most staff had the skills, knowledge and experience to deliver effective care and treatment, although we had concerns about the appropriate training of nurses who led the MIU and the difficulty encountered by the health visitors in receiving training.

- The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- All staff received appraisals and told us they felt well supported by senior staff and the provider organisation. The learning needs of most staff had been identified through a system of appraisals, meetings and reviews of practice development needs. However we found that health visitors had difficulty accessing clinical supervision and peer support, mainly due to the isolation this small staff group.
- The system of appraisal had failed to identify that nurses who worked in the nurse led MIU had not taken part in the appropriate training to fulfil their role safely and effectively. At the time of our inspection we spoke to the practice nurses as well as the clinical lead, and although some staff had attended study days on clinical topics, there were no clinical staff with accredited MIU skill based qualifications. The practice nurses provided a nurse led MIU service, but were not trained and qualified with MIU relevant skills that were required to run the service effectively and safely. The practice nurses were not equipped to assess, diagnose and prescribe treatment for the patients they were treating. Patients with suspected fractures were diverted or redirected to other MIUs or acute trusts as there were no X-ray facilities on site, and nurses were not trained on how to interpret them. The MIU was staffed by nurses who were non-medical prescribers for some of the time. However the nurse led MIU operated outside practice hours which meant there were times when a nurse may be on duty without the ability to prescribe any medicines.

We raised our concerns with the provider who immediately assured us that a GP would be on duty at all times to support the nurses in the MIU with the assessment of patients and the prescribing of any medicines, until such time nurses could access and complete the necessary training. At our unannounced inspection we found the MIU was operating with a nurse non-medical prescriber and a GP. However the GP employed to provide the support did not have up to date basic life support (BLS) training. We raised further concerns with the provider about the training of staff deployed to cover this service. We had, the same day, assurances that the MIU would be staffed only by a GP or an emergency care practitioner with relevant experience, qualifications and training to assess, diagnose and treat all patients during the opening hours of the service. These staff would be in place until such time as an appropriate training, development and supervision programme was in place for staff and there was a service level agreed with the commissioners. The practice assured us, and we saw evidence that, staff recruitment checks for locum GPs included ensuring up to date training in BLS. However the short notice recruitment of the GP to cover the MIU had not identified this shortfall.

At our unannounced inspection we were told that a number of further changes had been proposed to minimise any further risks to patients. The provider had taken action to source appropriate training for the MIU nurses and this had been booked. The provider had brought in a system of competency assessment and nursing staff had a received a copy of the framework. The nurse on duty explained they were due to meet with the clinical lead nurse from the provider organisation to work through the competency framework which included teaching and observed practice for a number of skills, situations and medical conditions.

- The nurses who worked in the MIU had a dual role and were also employed as practice nurses and we found the training and qualifications for the role of practice nurse were up to date and appropriate. Staff had access to appropriate training to meet their learning needs and to cover the scope of their practice nurse role. All staff had had an appraisal within the last 12 months.

Inadequate

Are services effective?

(for example, treatment is effective)

- Health visitors took responsibility to research relevant training and advice but had limited access to clinical supervision due the small and geographically isolated location of their team.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Since our inspection the practice has changed the range of services offered in the MIU as stated on the patient website.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services or when care was shared with the community services provided by the practice.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place every two months and that a virtual ward round took place every two weeks where care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service The practice occupational therapist and health care assistants had developed a better balance group to support those at risk of or had experienced falls. A smoking cessation clinic was held at the practice two afternoons a week. The practice nurses offered travel vaccinations and lifestyle appointments, at any time, for patients who may be in need of extra support.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 85.7%, which was better than the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to the clinical commissioning group and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds and five year olds were 90% for the year ending April 2015. Flu vaccination rates were below national averages for example for over 65s they were 69.42% compared with 73.24 nationally, and at risk groups were 45.62% compared with 52.29% nationally.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the five patient CQC comment cards we received and the 21 patients we spoke with were positive about the service experienced. Patients said they felt the practice staff were helpful and caring and treated them with dignity and respect. We also spoke with two members of the patient participation group on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards and patients highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice results were comparable to or above the national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 88.5% said the GP was good at listening to them compared to the CCG average of 91.9% and national average of 88.6%.
- 93.6% said the GP gave them enough time compared to the CCG average of 89.9% and national average of 86.8%.
- 99.2% said they had confidence and trust in the last nurse they saw compared to the CCG average of 97.8% and national average of 97.2%
- 88.5% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89.2% and national average of 85.1%.
- 95.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92.3% and national average of 90.4%.
- 85.9% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89.8% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages.

For example:

- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.1% and national average of 86.3%.
- 83.6% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86.1% and national average of 81.5%

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.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and the practice sign posted carers to support groups which met regularly. Those patients identified as carers were supported, for example, by offering health

Good

Are services caring?

checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, they were contacted by the practice or community service. This was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group and other practices in the locality to plan services and to improve outcomes for patients in the area. The practice was commissioned to provide community services for patients in the area including those registered at neighbouring practices.

Services were planned and delivered to take into account the needs of different patient groups and aimed to provide flexibility, choice and continuity of care. Although feedback from patients indicated that they did not always feel the practice had provided continuity of care in recent months.

- The practice offered late evening appointments two nights a week until 7.30pm for patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability or those with complex medical needs.
- The practice was able to use the facilities of the minor injuries treatment room should a practice patient become unwell or require urgent treatment. For example on the day of our inspection this facility was used by four practice patients who needed further support. The practice GP and nurse prescriber had used the facilities in the Minor Injuries Unit (MIU) to respond to the needs of their patient. For example to lie down to rest and recover or to wait for an ambulance in a place where equipment was available for the GP to monitor their condition.
- Home visits were available for older patients and patients who would benefit from these.
- Urgent access appointments were available for all patients with children and those with serious medical conditions being prioritised.
- There were disabled facilities with a hearing loop and translation services available.
- The practice provided accessible toilets and automatic doors which improved access for those patients with mobility difficulties. However the reception desk was at a level which could be a barrier to those patients who used a wheelchair.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with late opening Tuesdays and Thursdays until 7.30pm. Appointments were available during these times. Pre-bookable appointments that could be booked up to 12 weeks in advance, urgent appointments were also available for people that needed them.

The practice had a nurse led MIU which was open from 8am to 8pm on weekdays and from 8am to 1pm Saturdays, Sundays and bank holidays. This service was advertised as an emergency service, there was a list of services they were able to offer in the practice leaflet and on the practice website which included limb injuries, minor head injuries, sudden neck pain and suspected fractures and broken bones. We were told that patients that attended the MIU with injuries outside the scope of the nurses working there were re directed to another MIU approximately 10 miles away or an A & E department 26 miles away. Following our inspection the wording on the practice website and signage at the practice was changed with references to an emergency service removed.

The MIU operating from the practice premises was advertised at the entrance to the practice as an 'Emergency Treatment Centre' and the door to the treatment room was labelled as 'Casualty'. The practice website also advertised the emergency service available. The patient perception of this unit was that they could access emergency care. At our unannounced inspection we saw that the signs indicating that the MIU was an emergency or casualty service had been covered.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was lower than local and national averages.

For example:

- 73.7% of patients were satisfied with the practice's opening hours compared to the CCG average of 78.8% and national average of 75.7%.
- 73.7% patients described their experience of making an appointment as good compared to the CCG average of 82.3% and national average of 73.8%.
- 62.1% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68.3% and national average of 65.2%.

However:

- 91.1% patients said they could get through easily to the practice by telephone compared to the CCG average of 85.3% and national average of 74.4%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

This data matched the information received from patients we spoke with on the day of our first inspection. All patients acknowledged that if their need was urgent they could access an appointment the same day. However there were a large number of comments received about the lack of continuity of care. Patients told us that over recent months they had attended the practice and in some cases had seen a different GP each time. They told us that this had meant they had needed to repeat information to the GP or sit and wait while the GP had read their record. The practice had identified these concerns and had discussed these concerns at practice meetings. We were told that this situation had been the result of staff sickness and the practice had worked to secure regular locums to cover in an attempt to improve continuity of care. The practice could demonstrate that no GP consulting time had been lost

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system a summary leaflet was available. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 30 complaints received in the last 12 months for both the GP practice and the community services and found these were satisfactorily handled and dealt with in a timely way. All complaints were reported to the provider organisation to allow them to have an overview of the service and to identify any trends or themes. A theme was patient dissatisfaction with the lack of continuity of care and the lack of a permanent male GP. The practice had recruited a male GP, however they would not be in post until December 2015 and as an interim measure had ensured a male locum GP was available as often as possible.

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 clear vision to deliver high quality care and promote good outcomes for patients. The practice had a vision statement, 'Providing Good Enough Care for Our Own Families'. Their aim was to make a real difference to peoples' lives. The vision and aims were underpinned by six values. Staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Our findings at inspection demonstrated that the provider and staff were delivering this service to their patients in the GP practice and through the community services they provided.

Governance arrangements

The practice and the provider organisation had an overarching governance framework which supported the delivery of good quality care. This outlined the structures and procedures in place which aimed to ensure that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

However these governance arrangements had not identified the risks to patient safety in regard to the provision of care and treatment in the minor injuries unit (MIU). It had not been identified that supporting guidelines available for staff were out of date. Audit and appraisal had not been sufficiently robust to recognise that staff leading the MIU did not have the appropriate training and support to carry out their role effectively and safely.

Although there was a plan of clinical audits, governance systems had failed to recognise that clinical audit cycles had not been completed to monitor the quality and safety of the services provided.

Leadership, openness and transparency

The GPs in the practice and the service managers had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The senior managers and GPs were visible in the practice and staff told us they were approachable and always had time to listen to all members of staff. The provider organisation, managers and GPs encouraged a culture of openness and honesty.

Staff told us that weekly full staff meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at staff or team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the service manager in the practice. All staff were involved in discussions about how to run and develop the practice. The provider encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys, the friends and family test and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and provided patient feedback to the practice. The practice also published 'You Said, We Did' which listed their responses to patient feedback. This included the addition of a handrail outside the ground floor entrance, contact with the local school to provide artwork to brighten up the waiting room and contact the telephone supplier to ensure that if the practice telephone a patient this did not show as number withheld. This gave patients the opportunity to recognise it was the practice calling them.

The practice had also gathered feedback from staff through a six monthly staff survey 'Have Your Say'. The most recent had been conducted in April and May 2015. This was analysed at practice level and by the wider organisation. This was a way of capturing how staff could be supported in their role and any ideas and solutions staff wanted to share. They also gathered feedback through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or

Are services well-led?

Requires improvement

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

issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. They also commented positively on the level of support they received which had improved with the involvement of the provider organisation.

Following the issues raised by us at the first inspection of the practice the provider immediately took action to address those concerns. Within 24 hours the practice told us there would be a GP available to oversee the MIU at all times when it was open. Within 24 hours of our unannounced inspection the practice provided us with further assurance that the MIU would be led by an emergency care practitioner or GP with relevant experience and qualifications. They also provided us with an action plan which included: a review of the MIU clinical staffing arrangements, a review of staff qualifications, experience, training and development and supervision arrangements, a review of protocols and guidance. The serious concerns identified on the days of inspection were considered by CQC to pose a significant risk to patient safety. However, the provider acted promptly and took immediate corrective action against the most serious issues raised. This demonstrated a positive leadership approach to effectively manage risk and improve patient safety.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and had a plan for innovation and the future. These included the aspiration to employ a pharmacist to support medicines management and to develop 'Telehealth' technology to support patients to manage their chronic disease whilst at home.

The practice had developed a 'Better Balance' programme to support people who were at risk of, or who had experienced, a fall. Patients could be referred by their GP or nurse from the practice or neighbouring practice to the programme. Patients were screened by a health care assistant, from the practice's community team; visiting them in their home to assess the environment, check medication and take blood pressure. Any issues were raised with the patient's GP. Details were reported back to the practice's occupational therapist and the patient was invited into the practice for a 10 week exercise programme. The course consisted of an exercise programme to improve balance and educational sessions such as; diet and fluid, visits from the sight and hearing team, falls prevention and a talk from the practice social worker on social support and benefits.

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 17 HSCA (RA) Regulations 2014 Good governance The governance arrangements in place at the practice were not effective as they had failed to identify the risks and to patients who may attend for treatment in the minor injuries unit. Audit cycles had not been completed How the regulation was not being met: The provider had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (2) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff generally felt well supported by the practice with good access to training. However Nurses in the Minor Injuries Unit had not received the training necessary for their role and Health Visitors had not been supported to access training in order to keep up to date with current practice. How the regulation was not being met: The provider had not ensured that staff had received appropriate support, training and professional development as necessary to enable them to carry out the duties they were employed to perform. Regulation: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks relating to the provision of the service in Minor Injuries Unit (MIU) had not been assessed. Staff working in the MIU did not have the training at a level recommended for the provision of urgent care. Medicines had been issued without the appropriate authorisation. How the regulation was not being met: The provider had not assessed the risks to the health and safety of patients of receiving care and treatment; they had not done all that was reasonably practicable to mitigate any such risks. The provider had not ensured that persons providing care and treatment had the qualifications, competence, skills and experience to do so safely. The provider had not ensured the safe management of medicines. Regulation: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (2) (a) (b) (c) (g)