Jordanthorpe Health 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 well-led?

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a focused unannounced inspection of this service on 13 June 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned following feedback to the Care Quality Commission which raised specific concerns about care and treatment and management of the practice.

This inspection report relates to the specific areas we reviewed as a result of the feedback received. We inspected the Darnall Primary Care Centre site only. As we did not look at the overall quality of the service we are unable to provide a new rating for the service.

Our key findings across the areas we inspected on 13 June 2017 were as follows:

- There was a system in place for reporting and recording significant events and incidents. We saw evidence significant events and incidents were analysed and action had been taken to prevent the same thing happening again. We saw evidence of learning and communication with staff following incidents.
- A diabetic audit had had been completed and action had been taken to identify patients with a new diagnosis of diabetes to improve patient outcomes.
- Complaints were recorded and handled in an appropriate manner.
- We saw policies were in place to govern records management activity and processes were in place to manage clinical tasks. However, systems to manage administration tasks were not effective. There were shortfalls with regard to security of blank prescription forms, patient identifiable information and monitoring of infection control procedures.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure blank prescriptions are stored securely as specified in the NHS Protect: Security of Prescription forms guidance 2015.
- Ensure security of patient identifiable information in line with the Data Protection Act 1998.
- Ensure monitoring systems of infection prevention and control procedures are consistently implemented.
- Review and improve the process to manage administration tasks in a timely manner to improve patient outcomes and minimise risk and ensure a complete and contemporaneous record is maintained.

Summary of findings

In addition the provider should:

- Review and plan follow up of audits to contribute to continuous quality improvement activity.

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 well-led?

At our previous inspection on 14 and 15 November 2016 the practice was rated as good for providing well led services. We carried out a focused unannounced inspection of the Darnall Primary Care Centre site on 13 June 2017 following feedback to the Care Quality Commission which raised specific concerns about patient care and treatment and the management of the practice. As we did not look at the overall quality of the service we are unable to provide a new rating for well led.

- We saw policies were in place to govern records management activity and processes were in place to manage clinical tasks. However, we observed administration tasks dating back to 26 April 2017 with no evidence from the medical record or from staff we spoke with that these had been actioned.
- There were shortfalls with regard to monitoring of infection control procedures, security of blank prescription forms and patient identifiable information.
- There was a system in place for reporting and recording significant events and incidents. We saw evidence significant events and incidents were analysed and action taken to prevent the same thing happening again. We saw evidence of learning and communication with staff following incidents.
- We saw evidence of clinical audit. A diabetic audit had had been completed and actions had been taken to identify patients with a new diagnosis of diabetes to improve patient outcomes and minimise risk.
- We saw evidence complaints were recorded and handled in an appropriate manner.

Jordanthorpe Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A lead CQC inspector, a second CQC inspector and a GP advisor.

Background to Jordanthorpe Health Centre

The provider, Sheffield Health and Social Care NHS Foundation Trust provides a wide range of specialist mental health, learning disability, drug and alcohol misuse and social care services to the people of Sheffield. From 1 April 2011 it became the provider of additional community and primary care services known as The Clover Group. The group which is made up of the main site at Jordanthorpe Health Centre has three branches at Darnall Primary Care Centre, Highgate and Central Health Clinic also known as Mulberry.

The organisation is an NHS Foundation Trust, accountable to Monitor and the Department of Health.

The four Clover Group Practices serve some of the city's most vulnerable areas. They have over 16,437 patients with 60% of the patient population from black and other ethnic communities. There are significant numbers of European migrants registered with the practices. The branch known as Mulberry is based in Sheffield City Centre and provides a specialist service to asylum seekers. This service includes a resettlement programme for immigrants entering the country and providing GP access to the homeless population and victims of trafficking.

The clinical team comprises of salaried GPs, advanced nurse practitioners, practice nurses, health care assistants and phlebotomists. The clinical team are assisted by support managers at three sites and a large administration and reception team. There is also a central senior management team which includes a Service Lead Manager, Clinical GP Lead and Operational Manager.

The practices are open between 8am and 6pm on Monday, Tuesday, Wednesday and Friday. On Thursdays the telephone lines close at midday at three sites and calls are transferred to the Mulberry practice where there is a duty doctor on call. Appointments are available at various times during the day across all sites these include walk in clinics, pre bookable appointments and telephone triage. One of the practices offers Saturday morning clinics which were available to all patients within the group. Patients had access to the services provided through the Prime Minister's Challenge Fund to hub sites across the City up until 10pm during evenings and weekends.

This inspection was carried out at the Darnall Primary Care Centre branch site only in response to feedback received by the Care Quality Commission.

Why we carried out this inspection

We carried out a focused unannounced inspection of this service on 13 June 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned following feedback to the Care Quality Commission to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection covers the specific areas we reviewed as a result of the feedback received. As we did not look at the overall quality of the service we are unable to provide a new rating for the service. The service will be re-inspected

in due course to confirm that they have carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 14 and 15 November 2016.

How we carried out this inspection

We carried out a focused unannounced inspection of this service on 13 June 2017. This inspection covers the specific areas we reviewed as a result of feedback received by the Care Quality Commission.

During our visit we:

- Visited the Darnall Primary Care Centre location only.
- Spoke with a range of staff (including: three GPs, support manager, operational manager, service lead, clinical GP lead, administration and reception staff).
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.
- Reviewed records relating to the management of the service.

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.

Are services well-led?

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

Our findings

At our previous inspection on 14 and 15 November 2016 the practice was rated as good for providing well led services. We carried out a focused unannounced inspection of the Darnall Primary Care Centre site on 13 June 2017 following feedback to the Care Quality Commission which raised specific concerns about patient care and treatment and the management of the practice. As we did not look at the overall quality of the service we are unable to provide a new rating for well led. This inspection covers the specific areas we reviewed as a result of the feedback received and observations made during this inspection.

Governance arrangements

There was a system in place for reporting and recording significant events (SEA) and incidents. We saw evidence significant events and incidents were analysed and action had been taken to prevent the same thing happening again. We saw evidence of learning and communication with staff following incidents. We reviewed the significant event analysis log which identified the practice were actively reporting significant events and incidents with openness and transparency. For example, a significant event was raised following a diagnosis not being entered into a patient's medical record following a blood test. This SEA was analysed and the procedure for handling results had been discussed with the GPs and the Results Protocol reviewed 6 October 2016 by the clinical GP lead.

We observed the system for filing blood test results and investigations. Results were colour coded, highlighting to the clinician that action may be required. A small group of staff were responsible for filing normal results and they were able to demonstrate an understanding of this role. All borderline and abnormal results were dealt with by the doctor on duty that day. We looked at the results awaiting action and they were managed in a timely manner.

We also saw evidence that incidents were reported through the Trust process. For example, following an incident where the telephone system had failed on 26 March 2017 and patients either received the engaged tone or were cut off. The practice had taken immediate action and contacted the telephone provider to rectify the problem. The service lead informed us they were aware patients were having difficulties getting through on the telephone to the Darnall site. On investigation they had identified that there was a problem with the telephone queueing system and patients were held in the loop system for long periods. We were informed the information technology department were working with the current telephone provider to resolve this and a schedule of works had commenced for a new telephone system although a telephony provider was yet to be selected by the Trust.

We reviewed the diabetic audit which had been completed in June 2016. This audit had been undertaken as a result of changes to national guidance to ensure appropriate monitoring of patients identified with a new diagnosis of diabetes. The audit also reviewed whether the diagnosis was recorded in the patients' medical record.

The clinical lead GP told us a clinical sub group was established following this audit to review the diagnostic pathway to address the use of the new national guidance. Following this the diagnosis protocol was revised in line with the new national guidelines. We saw evidence from team meeting minutes that the new protocol was discussed with the GPs on 3 August 2016 and that it was agreed the protocol would be implemented across all the sites from 9 August 2016. We saw evidence of a re-audit completed in May 2017. This showed that 63% of the patients identified at Darnall Primary Care Centre site and 75% of the patients identified across the other Clover Group sites had been reviewed. Following the re-audit, patients identified at the Darnall Primary Care Centre site had all subsequently been reviewed and action taken where needed. We reviewed four of these patient records and observed the diagnosis was recorded in the medical record and the patients had received appropriate treatment and monitoring.

During the inspection the practice re-ran the audit search on their clinical system. This identified 11 patients who did not have a diabetic diagnosis in their record. We reviewed six of these records. Reasons were evident in the record why they had not attended for an appointment. However, there were two patients identified who had not received any action or diabetic diagnosis, one from November 2016 and one from February 2017. The clinical GP lead told us that these had been reviewed whilst the inspection was taking place and appropriate action taken. The clinical GP

Are services well-led?

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lead told us that the patients identified at the other Clover Group sites on the re-audit were on the agenda to be discussed at the next clinical meeting scheduled for 13 July 2017.

We noted the practice had also set up searches to run daily on the clinical system to identify and monitor patients who had been identified, from blood tests, as being at risk of developing diabetes.

We observed the practice had some policies and protocols with regard to data management. For example, a Results Protocol, Document Management and Workflow Policy and Summarising of patient records/coding of incoming correspondence Protocol. We spoke with the staff who add information from hospital letters and results to patients' medical records. They understood their role and explained the procedure as outlined in their policies. We were told the on call duty doctor would deal with letters and results that required clinical input including any safeguarding issues.

Processes were in place to manage clinical tasks. However, we observed 74 administration tasks dating back to 26 April 2017 with no evidence from the medical record or from staff we spoke with that these had been actioned. We noted tasks were sent by clinicians to the reception staff to arrange appointments, investigations or to contact patients. For example, a request had been sent on 26 April to request a repeat x-ray investigation within four weeks for a patient. There was no documentation within the patient record to confirm action had been taken. However, staff we spoke with told us this had been actioned on the day of the inspection and not documented. Staff we spoke with told us low staffing levels was the reason some tasks were not done.

It was noted that there was a flagging colour coded system to highlight tasks that required prioritisation. For example, a task from 1 June 2017 had been flagged as urgent to send an appointment for one week's time to have a blood pressure check. There was no documentation in the patient record this had been completed. Staff told us there was no written procedure in place for dealing with these tasks that were flagged as urgent although they understood the meaning of the system.

Following the inspection the service lead told us that action had been taken but had not been recorded in the medical record for all the outstanding tasks seen for reason of not being able to contact the patient. We have asked the service lead for evidence to support this. We were informed following the inspection that a Task Policy had been developed which was due to be implemented from 12 July 2017.

We reviewed the complaints log and looked at three specific complaints received. Two verbal complaints and one written complaint. All had been handled appropriately. We saw evidence action was taken in response to complaints. The two verbal complaints had been given an explanation and apology and the written complainant had been written to and invited in to discuss their specific concerns with a GP.

We observed that the practice had documented on the complaints log any written or verbal complaints made by patients with regard to access and telephone access. It was noted that feedback from NHS Choices had also been included on this log. We spoke with the support manager regarding access to the service. We observed the next routine appointment with a GP to be in three weeks' time. Urgent appointments would be put on the list for the duty doctor to telephone back to arrange a suitable appointment if required. The support manager told us that the practice were trying to recruit more GPs but a recent advert for a GP had been unsuccessful. There was also a current vacancy for a nurse practitioner. The practice had in the last three months implemented an emergency care practitioner (ECP) role to complete home visits of patients to release GP time within the surgery. Some staff we spoke with told us at times they felt they had many jobs to do and sometimes there were not enough staff.

It was noted during the inspection that the disposable privacy curtains were dated 20 September 2016 and had not been replaced within six months as specified in The National Specifications for Cleanliness in the NHS for primary care medical premises. The sharps bin was dated October 2016 and had not been removed after three months as specified in NICE guidance 2012. We also observed in an unlocked consultation room blank prescription forms in the printer and found patient identifiable data in the form of prescriptions on the shelf.

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 Regulation 17 HSCA (RA) Regulations 2014 Good Governance. The registered persons did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. This was because: • Blank prescriptions were not always held securely. • Patient identifiable information was not kept secure. • There was a lack of monitoring and oversight of infection control processes. • A complete and contemporaneous record was not maintained with regard to administration tasks. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.