Newport Medical Group

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.

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Summary of findings

Overall summary

Newport Medical Group has a practice population of approximately 10,500 patients. Newport Medical Centre is one of three locations accessible to all of the patients registered with the group. Each of the three locations are registered separately with the Care Quality Commission (CQC). Only Newport Medical Centre was inspected on this occasion.

We inspected the practice at 1 Newport Road, Balsall Health on 5 August 2014 and completed a follow up inspection on the 18 August 2014. During the initial inspection we spoke with two doctors, the practice manager, operations manager, practice pharmacist, two nursing staff, members of the administration team and 13 patients visiting the practice. For two weeks prior to the inspection, patients had completed comment cards giving their views on the service provided at the practice. We also looked at the systems, procedures and policies the practice had in place. The information we gathered supported our judgement on whether the practice was safe, effective, caring, responsive to people's needs and well-led.

At the follow up inspection on the 18 August we looked at the recruitment records that had not been available during the first inspection.

During the inspection we looked to see how the practice met the needs of six specific population groups. There groups are; older people, people with long term conditions, mother, babies and young people, the working age population and those recently retired, people in vulnerable circumstances who may have poor access to care and people experiencing poor mental health.

We found that Newport Medical Centre had procedures in place for the safeguarding of vulnerable adults and children. Medicines, including emergency medicines and vaccines were handled and stored safely. The procedures at the practice for assessing and monitoring the risks and safety of the service were not sufficient for us to determine that the practice provided a safe service and environment for patients, visitors and staff.

The practice had procedures in place to deliver care and treatment to patients in line with the appropriate standards. Systems to improve the management and access for patients with long term conditions had been implemented.

We spoke with 13 patients; the majority spoke of a staff group at the practice who were caring. The comment cards we received gave positive feedback regarding dignity, respect and compassion. Our observations on the day of the inspection were that patients visiting and telephoning the practice were greeted appropriately with staff communicating in a variety of languages.

The practice was responsive to patients' needs. Patients were given the opportunity to give their views; the practice demonstrated how they listened to and responded to their patient group.

The provider was in breach of regulations related to: cleanliness and infection control, safety and suitability of premises, requirements relating to workers and assessing and monitoring the quality 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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There was a process and policy in place for safeguarding children and vulnerable adults from abuse. Medicines, including emergency medicines and vaccines were handled and stored safely.

There was a lack of awareness at the practice on the importance and necessity for robust safety systems and processes. The system for auditing and monitoring had not identified areas for attention and improvement. This included actions required in relation to infection prevention and control. The recruitment process at the practice did not ensure that patients were safe and that their health needs were met by fit, appropriately qualified staff that were registered with the relevant professional body.

The procedures at the practice for assessing and monitoring the safety of the service were not sufficient for us to determine that the practice provided a safe service and environment for patients, visitors and staff.

Are services effective?

Systems to improve the management and access for patients to health reviews of their long term conditions had been implemented. There were joint working relationships with community services and engagement with health and social care providers to co-ordinate care and meet people's needs.

Training certificates and competency assessments were not available to ensure effective staffing was in place.

Are services caring?

The practice was caring. Consideration was given to ensure patient confidentiality was maintained. Patients visiting and telephoning the surgery were greeted by friendly staff in an appropriate manner with staff communicating in a variety of languages which supported the individual needs of the patients.

Are services responsive to people's needs?

The practice was responsive to people's needs. Patients were given the opportunity to give their views. The practice demonstrated how they listened to and responded to their patient group. There was a system in place which supported patients to raise a complaint. Complaints were recorded, investigated and responded to.

There was not sufficient consideration to the layout of the building to support patients with mobility difficulties.

Summary of findings

Are services well-led?

The systems and processes in place did not ensure that risks were identified and mitigated before they became issues which adversely impacted on the quality of care. Analysis of incidents and complaints was not completed in order to minimise the risk of further occurrence. On the day of the inspection no one was able to confirm that a safe recruitment process was in place.

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

Newport Medical Centre has a much lower percentage of patients over 65 than the Sandwell and West Birmingham CCG area and England average. There is also a significantly high level of income deprivation affecting older people.

From April 2014 all practices will need to ensure that each patient on their practice list aged 75 or over is assigned a named, accountable GP. At Newport Medical Centre each patient was assigned to a named, accountable GP who had overall responsibility for the care and support of the patient. This would provide a more consistent approach to the patient's care. The patients in this population group that we spoke with confirmed that they had a named GP. Appointments for this GP were available, however requesting to see a named GP may result in a delay in being seen.

People with long-term conditions

A member of the administration team had been given responsibility to facilitate the long term conditions register. They reviewed each register, for example diabetes, on a monthly basis and contacted patients in order to arrange a convenient appointment for a review of their condition with either the practice nurse or a GP.

The practice recognised the long term condition needs of its practice population. For example, diabetes is more prevalent amongst some ethnic groups. This had led to Newport Medical Centre having a greater number of patients with diabetes than the expected national average. Services were being enhanced to support this patient group.

Mothers, babies, children and young people

The practice worked with Health Visitors and community midwives who ran ante-natal clinics at the practice.

There was a comprehensive safeguarding children policy in place. The policy included statements of intent, principles and definitions of the different types of safeguarding concern. Practice nominated leads were named within the policy, the named lead had received the appropriate training for this role.

Summary of findings

The working-age population and those recently retired

The practice provided extended surgery times four evenings per week, enabling working age patients to attend the practice at a time when it was more convenient for them. This included telephone and face-to-face consultations. Patients had the opportunity to attend one of three local practices.

People in vulnerable circumstances who may have poor access to primary care

Staff at the practice spoke eight languages which supported patients whose first language was not English. For additional languages a translation service was available.

Home visits by GPs and nurses were available for those patients who were too sick or unable to attend an appointment at the surgery. A drug and alcohol clinic was held at the practice weekly run by the community drug team. There was the opportunity for an immediate referral to the clinic when necessary.

People experiencing poor mental health

The practice worked in conjunction with the local mental health team, community psychiatric nurses and the Healthy Mind counselling service. The practice told us they aimed to improve patients' experience of mental health services and increase support for people when they were discharged.

Summary of findings

What people who use the service say

During the inspection we spoke with 13 patients. The majority were complimentary about the reception staff saying they were helpful and polite. Ten patients were happy with the care and treatment they received by the doctors and nurses. Others told us that there were not enough GPs and that they felt rushed during consultations. Five of the 13 patients we spoke with described difficulties in accessing appointments. This had also been reflected in the 2013 patient satisfaction survey.

Prior to the inspection we provided the practice with a comments box and cards inviting patients to tell us about their care. We received 29 responses all of which were positive. The feedback from patients confirmed that reception staff treated people with dignity and respect. They told us that generally appointments were available. Patients were complimentary of the care they received from the doctors and the nurses at the practice.

We spoke with four members of the patient participation group (PPG). PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. They told us that the management team at the practice liaised with the group to look at ways to further develop and improve the service provided to patients.

Areas for improvement

Action the service MUST take to improve

The practice must take action to address infection prevention and control to ensure that they comply with the 'Code of Practice for health and social care on the prevention and control of infection and related guidance'.

The practice must review access to and suitability of the premises to ensure it reflects British Medical Association guidance in relation to disabled people accessing and using the services at its premises.

The practice must take immediate action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff.

The provider must review its systems for assessing and monitoring the quality of the service provision and take steps to ensure risks are managed appropriately

The provider must ensure that any nursing staff who undertake breast examinations have the necessary training, skills and regular competencies assessments in relation to intimate examinations.

The provider must ensure that staff have sufficient knowledge and understanding with regards to the Mental Capacity Act and the role of the chaperone.

Newport Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a GP, a second CQC inspector, a deputy chief operating officer with experience in practice management and an expert by experience who has personal experience of using primary medical services.

Background to Newport Medical Group

Newport Medical Centre is based in the Sandwell and West Birmingham Clinical Commissioning Group (CCG)

The practice is one of three practices in the Newport Medical Group providing primary medical services to approximately 10,500 patients in the local community.

On the day of our inspection the practice had three permanent GPs, two of which were practice partners. Specialist areas covered by the GPs included minor surgery, child health surveillance, paediatrics and rheumatology. Additional clinical staff included a practice nurse and an advanced nurse practitioner, who was also the practice manager. There were seven administrative staff that supported the practice. A pharmacist also supported the practice one day per week.

The practice manager was responsible for all three practices in the Newport Medical Group. All staff rotated between the practices.

The practice offered a range of clinics and services including chronic disease management, cervical smears, dressings, injections and travel vaccinations.

The Badger Group provided primary medical services to the practice patients outside of normal surgery hours.

Why we carried out this inspection

We inspected Newport Medical Centre as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Prior to the inspection we reviewed a range of information we hold about the practice and asked other organisations

Detailed findings

to share what they knew. We held a listening event and reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 5 August 2014.

Are services safe?

Our findings

Safe patient care

The practice had named health and safety and infection control leads. There were basic health and safety and infection prevention and control audits completed annually. On completion of the audits there had been no follow up statement or action plan detailing the outcomes and improvements required to ensure standards were being and continued to be met. Health and safety and infection prevention and control did not appear as standing items on the team meeting agenda. Without a system to consistently monitor and assess standards the practice could not be confident that patients and staff were protected against the risk of injury or harm.

Information from analysis of incidents and complaints allows for actions to be put in place to minimise the risk of further occurrence. A GP told us that there was no log or routine audit of reported incidents, significant events or complaints. The lack of a process in place to identify potential risks and trends increases the risk of continued unsafe practice.

We asked the practice manager about fire safety. They told us that fire risk assessments were completed every six months. We saw a copy of a risk assessment completed in May 2014. The risk assessment stated that a fire drill had been carried out within the last six months; the action required was to maintain drills on a regular basis. The practice manager told us that planned evacuations and fire drills did not take place. As a result the practice had not established if the plan for evacuation, in the event of an emergency, was sufficient to ensure the safety of the patients and staff. Due to the inaccuracy in the fire risk assessment record, the practice was unable to demonstrate that the building was safe for patients, visitors and staff.

Learning from incidents

There was a system in place for reporting, and logging significant events which occurred at the practice. There was no system for recording analysing and learning from near misses (incidents which could lead to harm if they are repeated in future). Both GPs discussed the process in place for learning from incidents and gave an example of improved systems following an incident where a test result had not been reviewed. They told us that this had led to a change in practice which made the process more robust. There was no system in place to ensure the learning was appropriately shared with all appropriate staff.

Reliable safety systems and processes including safeguarding

A practice must ensure that all staff understand the signs of abuse and how to raise concerns with the right person. There was a comprehensive safeguarding children policy in place. The policy included statements of intent, principles and definitions of the different types of treatment that may lead to a safeguarding concern. Practice nominated leads were named within the policy. There was also a safeguarding vulnerable adult's policy available. Both policies held a signed list of staff that had read and agreed to abide by the policy. We saw that an electronic version of the policy was available to all staff at the practice.

Each of the staff members we spoke with were able to describe their role and responsibility in relation to safeguarding. We saw that training certificates were available which demonstrated that staff had received safeguarding training for both children and vulnerable adults.

We asked staff about the practice's policy for whistle blowing. This is a process which enables staff to raise concerns identified within the practice; this includes concerns of poor practice by colleagues. The staff we spoke with were aware of this process and were aware of their responsibility to raise any concerns they had.

Medicines management

When vaccines required storage between 2 and 8 degrees Celsius we saw that they were securely stored in a lockable medication fridge. Temperature checks were completed daily to confirm vaccines had been stored appropriately.

Cleanliness and infection control

We looked at how infection prevention and control was managed at the practice. There had been an annual infection control audit completed. Following the audit there had been no action plan developed to address the areas that required attention or improvement. During the inspection we noted areas that did not comply with The Health and Social Care Act 2008 'The code of practice for health and adult social care on the prevention and control of infections and related guidance'. For example the

arrangements for cleaning should include clear, agreed and available cleaning routines. The cleaning schedule we saw held minimal detail and had not been completed since 25 June 2014. There was no system in place for auditing or monitoring the cleaning schedules to ensure that patients were not exposed to healthcare associated infections. We also identified a number of environmental concerns. For example the Health and Safety Executive (HSE) guidance regarding legionella is for a completed risk assessment. The risk had not been considered. The infection control lead told us there was a schedule of work planned at the practice to improve infection control. However, these areas had not been identified during the practice's infection prevention and control audit.

As part of the infection prevention and control process the practice should hold a record of clinical employees' hepatitis B immune status. Clinicians who come into contact with blood products are at increased risk of being infected with hepatitis B. The practice did not routinely check and record staff member's hepatitis status therefore this information was not available at the time of the inspection.

Staffing and recruitment

Schedule 3 of the Health and Social Care Act 2008 details information required to be available in respect of people employed at the practice. This must include photographic proof of identity, a full employment history and documentary evidence of relevant qualifications. To ensure that the practice operated effective recruitment procedures we asked to see the personnel files for individual staff members. We found that the required information was not fully available during the inspection. We revisited the practice on 18 August in response to the practice sending information which indicated that the information had been collated. We checked the personnel files for seven staff members which included GPs, nurses and administrative staff. We found that there were incomplete recruitment records. There were gaps in the documentation for example; there was no evidence that qualifications had been verified, references sought, and employment history checked. There was no process or policy in place to ensure staff members were eligible to work in the United Kingdom.

The skill mix of staff had not been considered. The practice manager also had responsibility as a nurse practitioner. The practice manager role, which was approximately 12 hours per week, was to support three practices with 10,500 patients. The right staffing levels and skill-mix must be sustained to support safe, effective and compassionate care and levels of staff well-being. Leadership at the practice was compromised due to the lack of practice management time. For example the practice manager was unaware that recruitment files did not hold the required documentation.

Dealing with Emergencies

We looked at the availability and storage of emergency medicines. A practice nurse gave examples of medicines held for emergency use which were stored securely.

There was equipment available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure the equipment was available and fit for purpose. A practice nurse told us that all staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

The patient leaflet gave patients information regarding urgent medical treatment both during and outside of surgery hours.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

We discussed effective patient management with a GP. They explained how they ensured best practice by following published guidelines, for example National Institute for Health and Care Excellence (NICE). We saw that both local and national guidelines were available and accessible on their surgery computer.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered.

A member of the administration team had been given responsibility for QOF. Their role was to facilitate the long term conditions register. They reviewed each register, for example diabetes, on a monthly basis and contacted patients in order to arrange a convenient appointment for a review of their condition with either the practice nurse or GP.

The practice recognised the long term condition needs of its practice population. For example, diabetes was more prevalent amongst some ethnic groups in the area. This had led to Newport Medical Centre having a greater number of patients with diabetes than the expected national average. A diabetes specialist nurse had been appointed to provide in-house diabetes clinics. Access to diabetes care for patients at the practice had improved as a result of this.

A primary care pharmacist worked at the practice one day per week. They told us that their role was to support the practice with medicines management and prescribing. They told us that they had identified that the practice were prescribing a particular drug over and above the expected level. A clinical audit was implemented to ensure patients were being prescribed medicines in accordance with best practice. A repeat of this audit showed us evidence that within a year of the initiative, the expected target had been achieved. The outcome of the audit demonstrated good team working which led to good outcomes for patients from both quality and a cost effective perspective.

Effective Staffing, equipment and facilities

During the inspection we looked to see if patients received effective care from staff who received appropriate training, professional support and development. There was an induction policy and process in place. The staff we spoke with said that they had annual appraisals. They told us that they felt supported and that training was available appropriate to their role. We were given examples of training that staff had received which included, for example safeguarding children. The practice manager was confident that staff had the necessary qualifications required for their role; however training certificates and competency assessments were not available to ensure effective staffing was in place.

The practice manager told us that discussions were being held to further improve effectiveness. They told us this included reception staff receiving training on how to redirect patients to other more appropriate care services such as pharmacy or community care. There was a delay in the development whilst consideration was given to the appropriateness and safety of the initiative.

Working with other services

There was engagement with other health and social care providers to co-ordinate care and meet people's needs. The practice manager told us that a drug and alcohol clinic was available which was provided by the community drug team. They also told us that multi-disciplinary team meetings were held every 12 weeks, attended by GPs, nurses, a primary care specialist pharmacist, a community matron and district nurses. These meetings were minuted. The practice manager told us that joint working with the district nurse team was being further developed.

Health, promotion and prevention

The practice manager told us that all new patients were offered a consultation. They told us that at registration, patients were given a questionnaire. An appointment was arranged to see a practice nurse within two weeks of registration. A general health check, details of current medicines and relevant health history was taken and entered into the practice computer. We were told that health advice and literature was given where appropriate. There was a system called 'due diary date' in place to alert staff that the new patient had not attended a routine health check within two weeks. A consultation for new patients ensured that the practice had the opportunity to ascertain details of each patient's past medical and family

Are services effective?

(for example, treatment is effective)

histories. There was also an opportunity to collect information in relation to social factors including occupation and lifestyle, medicines and measurements of risk factors for example smoking, blood pressure and weight monitoring together with alcohol intake and smoking status.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw a variety of health and welfare information displayed in the waiting area informing patients about health promotion and prevention. Some but not all of this information was available in alternative languages. There was access to interpreting services should additional translation be required.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

A practice must uphold and maintain the privacy and dignity of patients. A practice policy for equality and diversity was available. Practice staff had signed to say they had read and understood the policy. We observed that when patients arrived at the practice, staff greeted them in a polite and courteous manner. The majority of the 13 patients we spoke with gave positive feedback regarding the service provided by the administration team, including receptionists. The feedback we received was that generally people who used the service felt supported and well-cared for. All 29 comment cards completed by patients gave positive feedback.

A chaperone can be present during intimate examinations as an impartial observer who will be able to reassure the patient. We saw that the practice had a chaperone policy in place. While there was no formal training provided to staff, the staff had all signed to say they had read and understood the policy. We spoke to staff members about chaperoning. The role and responsibilities described by some staff did not reflect the 2013 published General Medical Council (GMC) guidance for 'Intimate examinations and chaperones'. The absence of training had resulted in an inconsistent approach with clinical and non-clinical staff having differing understanding of their role and responsibility.

We saw that staff approached people in a person centred way; they respected people's individual culture, faith and background. In total there were eight languages spoken by staff at the practice. A translation service was available for any language not covered by practice staff. The staff members we spoke with said that the interpreting service was available for all patients. They told us that interpreting by family members was discouraged. This was contradicted by information in the waiting room informing patients of the need to bring an interpreter with them.

A GP at the practice told us that they provided their contact number to the out of hour's service provider who would contact them if a patient who was terminally ill passed away outside of surgery hours. This was to ensure that, if appropriate, the doctor could support the family to maintain cultural beliefs. The doctor would offer additional support to bereaved relatives by conducting a bereavement visit to the home.

Involvement in decisions and consent

We asked nine patients if they had been involved in the planning of their care. Three had not felt involved. We spoke to one staff member about obtaining consent. They had good knowledge and understanding of consent requirements including children's consent guidelines. Not all staff had the same level of knowledge. Staff had not received training in this area. There had been no audit, review or competency assessments to ensure that all practice staff had the same knowledge and understanding of the requirement to involve their patient in decision making and consent to their care and treatment.

The Mental Capacity Act governs decision making on behalf of adults, and applies when patients do not have mental capacity at some point in their lives for specific decisions. When necessary patients must be assessed to determine if they lack capacity prior to a best interest decision being made. The GP we spoke with had an awareness of the Mental Capacity Act, but confirmed that further guidance and training for all staff would be appropriate and beneficial.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Newport Medical Centre is one of three practices run by Newport Medical Group. In order to meet the needs of the patients, staff at the practice told us that patients had access to appointments at all three locations. This enabled the practice to respond to patient's individual care needs, for example requiring an appointment with a nurse specialising in diabetes care.

The practice staff recognised the long term condition needs of its practice population. For example, diabetes was more prevalent amongst some ethnic groups. This had led to Newport Medical Centre having a greater number of patients with diabetes than the expected national average. A diabetes specialist nurse had recently been appointed to provide in-house diabetes clinics four afternoons per week across the three separate locations.

There were a high number of patients with cultural needs who required care and treatment from a female GP. In the absence of a full time female GP, some intimate exams were being carried out by the practice nurses. For example patients attending with breast concerns had examinations carried out by nursing staff. The nurses informed us that they had the appropriate knowledge and experience to carry out these examinations and nurses were acting in the best interests of the patients to meet their cultural needs. The provider should note that there were no certificates of training or competency assessments seen to demonstrate that staff had sufficient experience to complete these examinations. A female GP had been recruited with a start date pending.

Newport Medical Practice was not easily accessible to people with reduced mobility. Although a ramp and hand rails had been provided, throughout the day we saw that people who used walking aids and wheelchairs had difficulty entering the building due to a small step and a heavy, non-automatic door. This, together with a high, enclosed, reception desk, meant that wheelchair users were unable to independently access the service. The practice had followed British Medical Association guidance and completed an audit to determine how easy the practice was for disabled people to access and use services at its premises. They had however failed to implement reasonable adjustments to allow disabled patients independent access to the building.

In order to target our inspection effectively we reviewed the results from the national patient satisfaction survey. The results from 2013 placed the practice below the national average for patient satisfaction. Analysis from the survey identified that patients were generally unhappy with the availability and process for booking appointments. A member of the management team told us that staff and NHS England the service commissioner, had raised concerns regarding the number of appointments that were available for patients. In response to this, the practice had commissioned external assistance to analyse the appointment issues. The development of a system to improve access to appointments was underway. Improvements to telephone access had been made with the introduction of additional lines and a system for patients to queue for an available receptionist. We saw that the practice had initiated further patient surveys which identified patient feedback as improving.

Access to the service

Patients were able to request a telephone consultation. A nurse practitioner triaged patients over the telephone to redirect patients, if necessary, before accessing an appointment with a doctor. This would include signposting patients to the nursing team when patients required a blood test for example. The nurse practitioner explained that this helped to keep the doctors available for the more serious cases. To further support access to the service further consideration and development was being undertaken around patient triage.

Reception staff told us that patients who requested to be seen urgently were offered a same day appointment. Patients were given the opportunity to attend appointments at all three practices run by Newport Medical Group. If an urgent appointment was not available, the patient would be contacted by a practice nurse or GP and an appointment arranged. This would be a same day appointment if necessary. Home visits were triaged by a clinician in the same way appointments were. The doctor would speak to the patient over the telephone to determine if a home visit was the most appropriate action. The doctor, and the nurse practitioner, if necessary, took a flexible approach and conducted home visits at the end of surgery. Patient's access to appointments had improved with urgent appointments being based on a clinical decision.

Are services responsive to people's needs?

(for example, to feedback?)

A ramp and hand rails had been provided for patients. However the practice was not easily accessible to people with reduced mobility. Patients using walking aids and wheelchairs had difficulty entering the building due to a small step and a heavy, non-automatic door. This, together with a high, enclosed, reception desk, meant that wheelchair users were unable to independently access the service.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was 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.

Complaint information leaflets, in alternative languages were available in reception. On receipt of a complaint an acknowledgment letter was sent to the complainant within five working days. Following an investigation a response was provided. The final response gave complainants details of external agencies they could contact should they remain dissatisfied.

We were told by the operations manager that access to appointments had been raised as an issue in the patient satisfaction survey. They told us that there was a review of the appointment process being undertaken by an external consultancy. This was for support to help resolve the identified problems with access. The on-going review of the appointment system had resulted in an improvement in the feedback received from patients

Are services well-led?

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

Our findings

Leadership and culture

The practice manager and staff we spoke with articulated the values of the practice. All were confident and knowledgeable when discussing dignity, respect and equality. When speaking to the practice manager and staff the importance of quality was evident. However practice staff had little time set aside to consider ways to improve the leadership and culture of the practice. There was no clear strategy in place to communicate the vision and values of the practice. There was therefore scope to better demonstrate that the practice was delivering the desired outcomes for its patients and staff.

Governance arrangements

There was no clear structure to the governance arrangements at the practice. It was not clear who was responsible for making specific decisions, especially decisions about the provision and safety of the care provided at the practice. The systems and processes in place did not always ensure that any risks to the delivery of high quality care were identified and mitigated before they became issues which adversely impacted on the quality of care. For example analysis of incidents and complaints was not completed to minimise the risk of further occurrence.

The process for recruitment was not effective. There were no clear lines of responsibility for ensuring staff were appropriately qualified and registered with the relevant professional body. On the day of the inspection no one was able to confirm that a safe recruitment process was in place.

Areas requiring attention that were identified during audits and risk assessments were not always actioned. For example, the practice had followed British Medical Association guidance and completed an audit to determine how easy the practice was for disabled people to access and use services at its premises. They had however failed to implement reasonable adjustments to allow disabled patients independent access to the building. For example we saw that people who used mobility aids could not access the building independently. Although identified in the audit, it had not been addressed. The infection prevention and control audit was not sufficient as it had not identified the practice non-compliance with the with The Health and Social Care Act 2008 'The code of practice for health and adult social care on the prevention and control of infections and related guidance'.

Patient experience and involvement

There is a national satisfaction survey undertaken annually. The 2013 results of this survey placed Newport Medical Centre below the national average for patient satisfaction. Areas where the practice scored poorly were for example, making appointments and opening hours. The practice also completed its own survey twice yearly. Returned surveys were collated and analysed. An action plan was developed to identify areas requiring further improvement. The results showed that patient's satisfaction was improving. The survey results were made available on the practice website.

We spoke with four members of the patient participation group (PPG). PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. All four members were new to the group and had only had the opportunity to attend one meeting. They told us that their first impression of the PPG had been positive. They told us that the management team at the practice had liaised with the group to look at ways to further develop and improve the service provided to patients.

We looked at the minutes from a PPG meeting held in March 2014. The results from the latest satisfaction survey of 600 patients was discussed. All areas were surveyed, which included for example, appointments and opening times. Actions were agreed which included extending the appointment times for one doctor when seeing patients with complex needs.

Identification and management of risk

The practice did not demonstrate that there was a strong culture with regards to the identification and management of risk. There was no systematic approach to identifying, recording and responding to risks.

Risk assessments and audits were in place, for example in infection control; however areas of concern that were identified by the inspection team had not been recognised or addressed by the practice. There was no schedule for safety checks such as fire alarm tests. The absence of these checks was confirmed by the practice manager.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Newport Medical Centre had a much lower percentage of patients over 65 than the Sandwell and West Birmingham CCG area and England average. There is also a significantly high level of income deprivation affecting older people.

From April 2014 all practices will need to ensure that each patient on their practice list aged 75 or over is assigned a named, accountable GP. The practice provided this service for the patients group. Each patient was assigned to a named, accountable GP. This GP had overall responsibilities for the care and support for the patient. Having a named GP responsible for co-ordinating care needs supported the patients with a consistent approach to their care. We spoke with three patients in this population group; each confirmed that they had a named GP.

The practice participated in the national immunisation programme to vaccinate patients aged 70 and 79 against shingles in support of proactive care. We saw that information was available in the waiting area to inform patients of this programme. Letters were sent to this group of patients and approximately 60% received the immunisation.

Reception staff told us that home visits and telephone consultations were available for elderly and frail patients who had difficulties accessing the surgery.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

A member of the administration team had been given responsibility to facilitate the long term conditions register. They reviewed each register, for example diabetes, on a monthly basis and contacted patients in order to arrange a convenient appointment for a review of their condition with either the practice nurse or GP.

The practice recognised the long term condition needs of its practice population. For example, diabetes was more prevalent amongst some ethnic groups in the area. This had led to Newport Medical Centre having a greater number of patients with diabetes than the expected national average. Services were being enhanced to support this patient group.

A diabetes specialist nurse had been appointed to provide in-house diabetes clinics four afternoons per week resulting in an additional 28 half hour appointments. The practice manager told us that attendance to the clinics had been extremely good. They gave examples of patient care and support that previously would have required a hospital referral. Access to diabetes care for patients at the practice had improved as a result of this.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

Newport Medical Centre had a higher percentage of patients in the under 18 age group than the Sandwell and West Birmingham CCG area and England average. There was a significantly high level of income deprivation affecting children.

There was a comprehensive safeguarding children policy in place. The policy included statements of intent, principles and definitions of the different types of treatment that may lead to a safeguarding concern. Practice nominated leads were named within the policy, the named lead had received the appropriate training for this role.

The community midwife ran an ante-natal clinic every Friday at the practice. A home visit would be arranged when appropriate for those who needed it. The practice manager told us that they operated a shared care service which meant that some anti natal appointments would be with a hospital consultant, some with a GP and some with a midwife. A GP told us how the practice met with and worked with the health visiting team to support mothers and babies.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The staff at the practice told us that they provided extended surgery times four evenings per week, enabling working patients to attend the practice at a time when it was more convenient for them. This was contradicted in the practice leaflet which stated that extended evening appointments were only available for emergencies. This included telephone and face-to-face consultations. Patients had the opportunity to attend one of three local practices.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

Newport Medical Centre has a much higher deprivation score than the Sandwell and West Birmingham CCG area and England average.

The practice manager told us that a drug and alcohol clinic was available provided by community drug team. Patients were referred to the clinic via the GP or nurse practitioner. They told us that clinical guidelines for drug testing and prescribing were followed. They gave details of positive outcomes for patients following the support from the clinic. We were told that prior to setting up the clinic; there was a long waiting list for treatment. There was no waiting time with immediate referrals and appointments being available. This early intervention had an impact on the patients, families and the wider community.

Staff at the practice spoke eight languages which supported patients whose first language was not English. For additional languages a translation service was available.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice worked in conjunction with the local mental health team, community psychiatric nurses and the Healthy Mind counselling service. The practice told us they aimed to further improve each patient's experience of mental health services, and increase support for people when they were discharged from hospital.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Services in slimming clinics Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People were not protected from the risk of infection because appropriate guidance had not been followed.** **Regulation 12 (1) (a) (b) (c) (2) (a).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.** **Regulation 15 (1) (a)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Appropriate checks had not been undertaken before staff began working at the practice.** **Regulation 21 (a) (i) (ii) (iii) (b) (c) (i) (ii)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have effective systems to regularly assess and monitor the quality of the service.**

This section is primarily information for the provider

Compliance actions

Regulation 10 (1) (a) (b)