

The Wharf Family Practice

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

Good



Are services effective?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at The Wharf Family Practice on 30 August 2016. The overall rating for the practice was good with requires improvement for providing effective services. We found one breach of legal requirement and as a result we issued a requirement notice in relation to:

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 – Good Governance

The full comprehensive report on the August 2016 inspection can be found by selecting the 'all reports' link for The Wharf Family Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 26 October 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 30 August 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

The effective domain is now rated as good and overall the practice remains rated as good.

Our key findings were as follows:

- The practice had improved the governance procedures in place to ensure patients with long term conditions were effectively managed. Action had been taken to address errors in the reporting system.
- The GPs and named senior nurses were responsible for completing the coding on the electronic patient record and were able to clearly describe the rationale for exception reporting.
- Staff had a clear understanding of the recall system for patients with long term conditions.
- The practice had improved their clinical exception rate from for exception reporting 21% to 14%.
- The practice manager had altered some of the standard letters sent to patients inviting them for a review to be more informative about the risks associated with the condition.
- The practice was taking positive action to address areas where results below the expectation.

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 effective?

The practice is rated as good for providing effective services.

- Improvement had been made to the governance procedures in place to ensure patients with long term conditions were effectively managed. The practice had identified errors in the reporting system and taken action to address these.
- The GPs and named senior nurses were responsible for completing the coding on the electronic patient record and were able to clearly describe the rationale for exception reporting.
- Staff had a clear understanding of the recall system for patients with long term conditions.
- Monitoring of progress towards targets took place on a weekly basis.
- The practice had improved their clinical exception rate from for exception reporting 21% to 14%.

Good



Summary of findings

The six population groups and what we found

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

People with long term conditions

The provider had resolved the concerns for effective identified at our inspection 30 August 2016 which applied to this population group. The population group ratings have been updated to reflect this.

- Improvement had been made to the governance procedures in place to ensure patients with long term conditions were effectively managed.
- Clinical staff were supported by the community diabetic nurse who hosted monthly clinics at the practice.
- Nursing staff had been provided with additional training so they were able carry out all of the required long term condition checks. For example nursing staff had been supported to attend specialist courses in spirometry (a breathing measurement test) and also COPD (chronic obstructive airways disease).

Good



The Wharf Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

- Two female salaried GPs plus locum GPs
- A male nurse practitioner, a female practice nurse and female health care assistant (HCA).
- A practice manager supported by administration and reception staff.

The practice is open between 8am and 6.30pm Monday to Friday and appointments were available during these times. The practice offers extended hours on Mondays and Thursdays from 6.30pm to 8pm. In addition, extended opening hours were also provided on Saturdays from 9am to 12pm.

The practice has opted out of providing out-of-hours services to their own patients and this service is provided by another provider.

Background to The Wharf Family Practice

Phoenix Primary Care Limited is registered with the Care Quality Commission (CQC) as an organisation with primary care services across the country. The Wharf Family Practice (which is part of Phoenix Primary Care Limited) is located in Walsall, West Midlands, providing NHS services to the local community. The practice has an Alternative Provider Medical Services contract (APMS). APMS contracts are contracts between NHS England and general practices for delivering general medical services with a number of additional services. The contract is time limited.

The Wharf Family Practice is part of the NHS Walsall Clinical Commissioning Group (CCG). The practice provides GP services in an area considered as one of the more deprived within its locality. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial.

The patient list is approximately 3700 of various ages registered and cared for at the practice. The practice serves a higher than average patient population aged between 0 and 15 years and aged between 20 and 45 years. The practice also had a lower than average patients registered aged 40 and over.

The staffing consists of:

Why we carried out this inspection

We carried out an announced comprehensive inspection at The Wharf Family Practice on 30 August 2016. The overall rating for the practice was good with requires improvement for providing effective services and people with long term conditions. The full comprehensive report on the August 2016 inspection can be found by selecting the 'all reports' link for The Wharf Family Practice on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of The Wharf Family Practice on 26 October 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

Detailed findings

How we carried out this inspection

We carried out an announced focused inspection on 26 October 2017. During our visit we:

- Spoke with a range of staff including a GP, lead nurses within the organisation, the practice manager and the administrator.

- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at the systems that the practice used to monitor progress towards meeting the quality and outcome framework.

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 effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 30 August 2016, we rated the practice as requires improvement for providing effective services and issued a requirement notice. This was because the arrangements for managing and monitoring patients with long term conditions needed improving.

These arrangements had improved when we undertook a follow up inspection on 26 October 2017. The practice is now rated as good for providing effective services.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2016/2017 showed that the practice achieved 90% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The practice had improved their clinical exception rate from 21% to 14%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

The practice had improved the governance procedures in place to ensure patients with long term conditions were effectively managed. Following our previous inspection the practice had reviewed the process of exception reporting, including how codes were applied and who was responsible for updating the electronic system. The practice identified that staff who updated the system had not received appropriate training, which resulted in errors in coding which had led to increased rates of exception reporting.

One of the GPs had the lead role for QOF and was supported in this role by senior nurses who worked for the provider within the locality. The coding for exception reporting on the electronic system was only completed by GPs or the named senior nurses. The GP and senior nurses clearly described the rationale for exception reporting patients. We reviewed the records of five patients who had

been exception reported for either diabetes or asthma during 2016/2017. We saw that the reason for exception reporting had been clearly recorded and in each case the exception reporting was appropriate.

The practice had identified that the nursing staff had not been provided with the necessary skills and knowledge to carry out all of the required long term condition checks. Consequently nursing staff had been supported to attend specialist courses in spirometry (a breathing measurement test) and also COPD (chronic obstructive airways disease).

Staff spoken with had a clear understanding of the recall system for patients with long term conditions. The administration staff reviewed the registers of patients who needed to be reviewed each month, and contacted these patients either by telephone and /or by letter. Evidence of this was seen on the electronic patient record. The practice manager also submitted a weekly report for all QOF outcomes to the provider, which identified progress towards meeting the QOF targets. This information was collated into a league table for all practices, enabling the practice manager and staff to compare themselves against other practices within the Phoenix Primary Care Limited group.

We were shown that five percent of the patient population for the surgery had diabetes. The community diabetic nurse hosted monthly clinics at the practice. We looked at the management system the senior nurses had set up to achieve the QOF score for this group of patients. We saw that most scores were within the planned target. Foot risk assessments for diabetic patients were not within the target set by the practice. We saw that the practice manager had altered the standard letter sent to patients to be more informative about the risks associated with the condition. The nurses told us that they would be monitoring this to see if the new letter encouraged patients to book assessments.

We saw that the number of patients with asthma who required frequent monitoring in order to be able to stay well was within normal target range.

We saw the practice had responded to the needs of its fluid patient group with opportunistic targeting for people with long term conditions for which there was a QOF target. Staff made good use of the alert system on the electronic patient record to identify any tests, for example blood pressure checks, that were required.

Are services effective?

(for example, treatment is effective)

The practice provided care to a number of patients who lived in care homes. The practice had recently employed a nurse practitioner, who would be carrying out the long term condition reviews on these patients.

The practice had identified that the percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been over a period of time was below the expected rate. Staff were reviewing the register and either inviting patients in for blood tests if outstanding or for a medicine review with the GP if their blood result was raised.

Supporting patients to live healthier lives

The practice had taken action to increase the update of cervical screening and reduce the level of exception reporting. An outreach nurse from the Clinical Commissioning Group (CCG) supported the practice by providing dedicated clinics for those patients who had not been attending these health checks. These clinics commenced in March 2017 and we saw that by September

2017 these clinics were full with no missed appointments. We were shown a list of the number of patients who required cervical screening during 2017/2018: 74% of these patients had already attended for screening with the remainder of the patients having received an invite to attend.

We saw that figures for immunisations for children up to 4 years of age were well within national range. The practice had already achieved over 50% of the target for those patients who required the influenza vaccination during 2017/2018.

The practice had also identified that the number of patients living with dementia on their register was lower than expected. The practice manager had liaised with the Specialist Dementia Nurse at the local hospital to compare the practice register against their register identified through the Butterfly Project to see if any patients known to the hospital were not on the practice register. A similar project was taking place for patients with a learning disability.