Sherwood Rise 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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Sherwood Rise Medical Practice on 21 September 2015. This was to check that improvements had been made to meet legal requirements from the last inspection on 11 November 2014. This inspection will not result in a change to the practice's published ratings.

Summary of findings

The overall rating for this practice remains as 'requires improvement'.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sherwood Rise Medical Centre on our website at www.cqc.org.uk

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and managed, with the exception of those relating to recruitment checks and arrangements to deal with some emergency situations.
- Gaps in training for some staff in the management of long term conditions had potential to place patients at risk of receiving care that was not evidence based.
- The practice had a number of policies and procedures to govern activity. However whilst some of these policies had been updated, there were still several which required attention.
- The practice had now formed a small Patient Participation Group (PPG) which had provided some feedback as to how things could be improved

The areas where the provider must make improvements are:

- Ensure adequate procedures are in place for completing the required background recruitment checks on staff and that the information required under current legislation is available in respect of the relevant persons employed.

In addition the provider should:

- Review its arrangements for training to enable staff to respond appropriately in the event of an emergency. The provider should also review its records to ensure that staff training is appropriately recorded.
- Ensure that staff have access to appropriate and updated policies, procedures and guidance which are relevant to their roles.

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?

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However there are areas where the practice should make improvements in order to provide safe services.

The systems and processes to address the risks to patients who used the service were not implemented well enough to ensure patients were kept safe. Staff recruitment files did not contain information required under current legislation, such as documentation to provide assurance that all staff recruited were suitable and able to carry out their roles.

At the time of the inspection the practice were not able to demonstrate that the non-clinical staff responsible for chaperoning had either a Disclosure and Barring Service (DBS) check in place or that the roles of these staff had been risk assessed. However, following the inspection visit the practice provided evidence that all staff had received completed DBS checks.

Are services effective?

During our inspection in November 2014, we found that patients were at risk of receiving care that did not meet their needs or reflect their preferences. This was because patients with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) were not always identified and reviewed promptly. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. We also identified that delays had occurred in acting on test results. During the inspection in September 2015 we found that action had been taken to address these issues.

During our previous inspection we also identified that the practice nurse was assessing and reviewing patients with COPD without having received appropriate training. When we inspected again in September 2015 we found the practice nurse had received limited training which was still insufficient to enable them to carry out this role effectively. The practice nurse left the practice shortly after our inspection and one of the GPs had assumed responsibility for reviewing these patients. As a result the breach of regulations we originally identified had been addressed and so further action was not necessary.

Summary of findings

Are services well-led?

During our inspection in November 2014 we found that the practice did not maintain accurate records in relation to the way the practice was managed and the way patients were cared for. We also found that the practice's system to monitor the quality of the service and to identify and manage risks was not effective.

At our inspection in September 2015 we found that some improvements had been made in these areas, but further improvement is still needed. As a result, the requirement notices put in place following the last inspection will remain in place.

There was now a documented leadership structure, which had improved from our last inspection. All staff we spoke to told us that they felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. The staff recruitment policy was dated 2009.

The practice now had a small but active patient participation group (PPG).

All staff were receiving appraisals and whilst they had been encouraged to attend training the training records were not updated. Several members of staff had not had their CPR training, although a date had been booked for November 2015.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure adequate procedures are in place for completing the required background recruitment checks on staff and that the information required under current legislation is available in respect of the relevant persons employed.

Action the service SHOULD take to improve

- Review its arrangements for training to enable staff to respond appropriately in the event of an emergency. The provider should also review its records to ensure that staff training is appropriately recorded.
- Ensure that staff have access to appropriate and updated policies, procedures and guidance which are relevant to their roles.

Sherwood Rise Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included an Inspection Manager.

Background to Sherwood Rise Medical Centre

Sherwood Rise Medical Centre provides primary medical services to approximately 3,500 patients and is part of Nottingham City CCG. This practice is situated in an area which is considered to have a deprivation rate higher than the England average. The practice has a multi-ethnic population with approximately 25% of patients registered being from Eastern European or Asian populations. The GPs and several of the administrative team, including receptionists are multi-lingual; however there is access to an interpreter service if required.

The practice has two GP partners and one part time salaried GP. Only one partner works full time. There are two female GPs and one male GP. The practice employs a full time practice nurse and a part time member of staff with a dual role of receptionist and health care assistant. Both of these members of staff are female.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services. However the practice has opted out of providing out of hours services to their own patients and there is information on the website and practice answer phone advising patients how to contact the out of hours service outside of practice opening hours.

Why we carried out this inspection

We undertook an announced focussed inspection on 21 September 2015. The aim of this inspection was to check that improvements had been made to meet legal requirements, following our comprehensive inspection on 11 November 2014. We inspected the practice against three of the five questions we ask about the services: are services safe, effective and well led. This was because the practice was not meeting some legal requirements in those areas.

Are services safe?

Our findings

Safe track record and learning

We reviewed the records of seven incidents and significant events and minutes from meetings where these were discussed since our last inspection in November 2014. We saw that there had been a significant improvement from our last inspection where we saw evidence that discussions had taken place and learning was being disseminated amongst all members of the clinical team. For example there had been an error where a patient who was from an ethnic minority background and who did not speak any English, had their clinical details entered into another patient's notes. We saw evidence that all receptionists and clinical staff now asked all patients for photographic ID and that this was reconfirmed with an interpreter, for those individuals who did not speak English, in order to avoid such an incident in the future.

Overview of Safety Processes

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. There was an accident log book available. The practice had up to date fire risk assessments and regular fire drills were carried out. We saw evidence that the electrocardiogram (ECG) machine used to take tracings of the heart, and clinical weighing scales had been calibrated. We also saw that lights and other electrical equipment had been tested to ensure that it was safe and fit for purpose.

The quality of infection control procedures had been an issue during the last inspection. Appropriate standards of cleanliness and hygiene were now followed. The premises were visibly clean and tidy. The practice nurse took the lead for infection control. She had received updated training in this area since our last inspection. There was an infection control policy which had recently been updated. We also saw evidence of an infection control audit which had been carried out by an external company in November 2014. There was an action plan in place and we saw evidence that this plan had been actioned. For example we saw that the baby changing mat was cleaned on a regular basis and that this was being monitored. Cleaning schedules were in the staff toilets, public toilets and all clinical rooms. We saw evidence that these were being completed on a daily basis.

From our conversations with the practice manager we were told that reception staff were trained to act as chaperones if nursing staff were not available. The staff we spoke with understood their responsibilities when acting as a chaperone. However, we found that none of these receptionists carrying out chaperone duties had received a disclosure and barring check (DBS) or a risk assessment around this. A DBS check helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. Following the inspection the practice manager provided evidence that all clinical and non-clinical staff at the practice, including those that carried out chaperoning, had received a DBS check.

Although the practice had a recruitment policy, this was dated 15 October 2009. We reviewed the staff recruitment files from several members of staff including, the practice nurse and administration staff. We found that robust recruitment procedures were not in place. We reviewed the staff file of a member of non-clinical staff who had been employed since 3 February 2014. There was no evidence relating to this member of staff's conduct during their previous employment or information about their previous physical or mental health. This did not provide assurance that the practice's recruitment policy operated effectively.

Employment records for the practice nurse did contain a DBS check, evidence of hepatitis B immunity and certificates of training. Checks had been carried out with due regard to nursing registration, ensuring that the nurse was legally qualified to undertake her role.

The practice was continuing to provide same day urgent appointments. The reception staff used a flow chart to help them to signpost patients to the appropriate clinician when making appointments. We were satisfied from our conversations with the reception staff that they knew what to do if a patient telephoned with chest pain which may be a sign of a medical emergency.

Arrangements to deal with emergencies and major incidents

We saw that emergency medicines to treat patients who may suffer severe allergic reactions to medicines were available in the consulting and treatment rooms and these were in date.

The practice had an automated external defibrillator (AED). This is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to

Are services safe?

attempt to restore a normal heart rhythm. Emergency oxygen was also available on the premises. The oxygen tank was supplied with adult and children's masks. Staff we spoke with knew where the emergency equipment could be located if required. There was also a first aid kit and accident book available.

Training records suggested that all staff received annual basic life support training. However we found that not all staff had attended cardiopulmonary resuscitation (CPR) training. Records showed CPR training had been booked for 18 November 2015.

During our last inspection we identified issues with some fire safety tests. However we saw evidence during this inspection that fire safety tests such as fire alarms and fire drills were carried out at regular intervals.

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

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There were concerns during our last inspection where it was unclear if GPs and nurses were completing assessments of patients' needs in line with NICE guidelines and that these patients were reviewed when appropriate. Prior to our last inspection the practice had been considered as an outlier in relation to the ratio of reported (as to expected, given the practice demographic) levels of patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD) which is a chronic lung disease). An outlier is where the data is significantly different when compared to other practices in the same CCG and the England average.

However we saw improvements whereby data from the Quality and Outcomes Framework (QOF) highlighted that the practice had now identified 90% of patients with COPD which was broadly in line with the CCG and national average. We saw evidence from patient records where a patient with asthma had been referred to secondary care (as per NICE guidelines) in order to confirm or rule out whether they had now developed COPD.

However the practice nurse, who was responsible for reviewing patients with COPD, demonstrated a very limited knowledge of both NICE guidelines and British Thoracic Society guidelines which should be used when managing patients with chronic lung disease. Ultimately this lack of knowledge had the potential to place patients at risk of not receiving safe evidenced based care.

Effective staffing

During our last inspection there had not been a practice manager in post taking overall responsibility for the day to day management and organisation of the practice. However there was now a practice manager in place albeit on a part time basis. There was evidence that the new practice manager had made some improvements. Staff were now aware of their individual roles and responsibilities. This meant that the practice nurse was no longer having to work as the practice manager and could concentrate on her own role as a nurse. We also saw evidence that key policies such as infection control had been updated and an infection control audit had been undertaken. We saw evidence of a list of policies that had been highlighted as requiring attention.

We were told that the senior partner had retired and left the practice since our last inspection. From our conversations with staff on the day, it was clear that staff morale was higher and relationships between colleagues had improved during the same period.

Staff training records at the practice identified that some members of staff had received training in areas such as child safeguarding, infection control and fire safety. However the same training records also indicated that several other members of clinical and non-clinical staff may not have received updates in these areas. We discussed this with the practice manager, who told us that the practice training records required updating and this was something she was working towards.

There were issues during our last inspection whereby the practice nurse was reviewing patients with COPD (a chronic lung condition) without formal training. Prior to our inspection the practice had submitted an action plan which stated that she had now undergone some spirometry training. However when we spoke with the practice nurse, she told us that this spirometry training consisted of a one day update. This lack of appropriate training had the potential to place patients at risk of not receiving safe evidenced based care. Shortly after the inspection, the practice informed us that the practice nurse had left and that all reviews for patients with COPD were now carried out by a GP.

There were issues from our previous inspection with staff appraisals where the practice nurse had not had an appraisal carried out by a clinical member of staff. From our conversation with the nurse she told us that she had recently had an appraisal with one of the GP partners. We saw evidence of this and the GP we spoke to also confirmed this appraisal had taken place.

Coordinating patient care and information sharing

There was an issue during the last inspection concerning GPs reviewing clinical notes received electronically or by post. These included patient attendance from out-of-hours care, blood test results, x-ray results and letters from the local hospital including discharge summaries. This had led to results from blood tests not being acted upon promptly. We saw evidence that this has improved. For example, when any such correspondence arrived at the practice either electronically or via the post, this was seen and triaged by a GP on the day. We saw evidence on the day of

Are services effective?

(for example, treatment is effective)

our inspection of one of the administration staff who scanned this information into the patient notes once it had been seen and relevant action taken in order to avoid a clinical incident.

Consent to care and treatment

During our last inspection concerns were raised with regards to GP knowledge of the Mental Capacity Act 2005. We saw some improvement during this inspection. From our conversation with the GP partner regarding mental capacity they were able to explain different aspects of the Mental Capacity Act and how they applied this in practice.

The nurse was able to tell us how she would safely gain consent prior to administering a vaccine or immunisation to a child.

Health promotion and prevention

There were issues arising from our previous inspection with low uptakes of vaccinations, immunisations and bowel and breast screening, whereby the practice was performing lower than other practices within the same CCG. However during this inspection the practice showed signs of improvement with its screening programmes.

- Data from the Cancer Tool Kit in the past 12 months indicated that 70.9% of women had attended for breast cancer screening which is in line with the current CCG average of 70.1% but marginally below the England average of 73.2%.
- 55.6% of adults aged 60 or over had undergone bowel screening which is above the CCG average of 53.8% and below the England average of 58.3%
- Latest childhood immunisation data suggests from the CCG during 2014-2015 indicated that the practice was achieving an 83.3% uptake of the MMR vaccine at 24 months which was below the CCG average of 91.48%. However, the practice had achieved a 78.4% uptake for the preschool booster for the MMR which is a significant improvement from 2013-2014. The practice were aware that the uptake of their vaccinations were lower than average, but had plans in place to improve their performance in this area.

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.

Are services well-led?

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

Our findings

Vision and strategy

During our last inspection we found that whilst the practice had a vision to deliver quality care and promote good outcomes for patients, we did not see evidence of any business plan.

During this inspection we found that the practice now had a business development plan in place for the next five years. This plan acknowledged the changing landscape in primary medical services, along with identification of challenges the practice was likely to face and suggestions provided as to how these challenges were to be addressed. However our evidence gathered during this inspection continued to identify shortfalls in how the practice was able to fulfil its vision due to gaps in its governance arrangements.

During our last inspection we had noted that the relationship between the senior partner and the other GPs was having a significant impact on their ability to provide effective patient care. A number of these areas were being worked on and we noted that some improvements had been made.

Governance arrangements

Since our last inspection there had been some improvements made to the practice's governance arrangements:

- With a practice manager now in place, there was now a clear staffing structure and staff were aware of their own roles and responsibilities.
- There were now regular monthly team meetings where significant events were shared and some complaints discussed. The reception team had their own meetings on a monthly basis and were working towards improving the appointment system.

However the evidence we gathered on the day of our inspection also highlighted areas where improvements were still required:

- Some practice specific policies such as the infection control policy had been updated, implemented and were available to all staff. However the practice manager was aware that many of the other policies required updating. We saw evidence of the list that the practice manager had made of such policies and the progress that had been made with this since our last inspection.
- We also found that the practice's record keeping in areas such as staff training did not support good governance. This was acknowledged by the practice manager

Leadership, openness and transparency

There was now a clear operational leadership in the practice. The senior partner had retired and relationships between the partners and staff had improved. This had led to some improvements in the quality and consistency of patient care. The partners were visible in the practice and staff told us how things had improved recently. Staff told us they felt supported and valued and there was an open and honest culture.

The receptionists we spoke with told us that they really appreciated their monthly meetings and felt that they could raise any concerns. They were committed to changing the appointment system to make it easier for the patients and spoke of how much they enjoyed their work now they had some clear leadership from the practice manager.

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

Whilst the practice did have a patient participation group (PPG), during our last inspection this was not active. However we noted that this was now active with five members. We saw evidence of a PPG survey and the results had been typed up, placed on laminated cards and posted on the main surgery notice board and in the patient toilets. The practice manager acknowledged that the number of PPG members was small and that it had been a struggle to recruit new members. She told us plans were in place to raise awareness of the PPG and try to recruit more individuals from different backgrounds.

Staff now told us that they felt involved with how the practice was being run and were positive about the future.

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
	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed **How the regulation was not being met:** We found that the provider had not protected people from the risks of unsafe or inappropriate care and treatment by ensuring that all of the required information in respect of each person employed was available and up to date. Regulation 19 (3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014