Packmoor Medical Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Packmoor Medical Centre on 3 December 2014. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, responsive and well led services. It also required improvement for providing services for the people with long-term conditions, older people, families, children and young people and working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people with poor mental health (including those with dementia). We found that the practice was good at providing caring services.

Our key findings were as follows:

- Patients were not always kept safe as the arrangements in place for recording, investigating and learning from risks to safety were not robust. The practice was not reporting significant events effectively which could result in a lack of learning , and compromise safety
- The majority of the patients we spoke with mentioned difficulty in accessing the practice by telephone. The most recent GP national patient survey data supported these views.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a lack of on-site clinical leadership which caused confusion over team members' roles and responsibilities.

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

Importantly, the provider must:

- Improve the recording, investigation and dissemination of learning from significant events.
- Regularly seek the views of patients using the practice.

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In addition the provider should:

- Review policies and procedures to ensure they are current and in date.
- Investigate the cause of higher than expected results in relation to antibiotic prescribing and amend practise if necessary.
- Review the business continuity plan and mitigate risks.
- Record minutes of meetings to assist in information sharing and activity governance.
- Review patients identified on practice registers as needing higher level support.
- Ensure that the method of complaint recording reflects all complaints received.
- Understand and record the demographic ethnicity breakdown of all patients registered at the practice.
- Ensure that telephone access for patients contacting the practice is fit for purpose.
- Review the arrangements for clinical leadership at the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough or recorded in a timely manner. Lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. We found instances of when patient safety had been compromised. Minutes from clinical governance meetings were not always taken, so staff who did not attend had no reference for action points or learning shared.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or just above average for the locality. Knowledge of and reference to national guidelines was inconsistent. There were completed audits of patient outcomes. There was higher than average antibiotic prescribing but no evidence that any action had been taken to determine the cause or to improve the situation. Multidisciplinary working was taking place, but was generally irregular and record keeping was limited or absent.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice to similar levels as others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Data showed that patient satisfaction with contacting the practice was below both the local and national average. Patients said they could not always contact the practice by telephone easily. The practice had not put in place a plan to secure improvements for all of the areas identified. Feedback from patients

Summary of findings

showed that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs. We saw that although complaints were investigated, they were not always recorded.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and a strategy and staff were supporting this. There was a documented leadership structure and most staff felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. We were told that governance meetings were held every month. However we could not evidence this as record keeping of these minutes was very limited or absent for most months. The practice had not recently proactively sought feedback from patients. The practice patient participation group (PPG) was not being used effectively. All staff had received inductions, but it was not clear if all staff attended staff meetings and events due to the lack of records kept.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice was rated as good for caring overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe, effective, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The practice was rated as good for caring overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe, effective, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Emergency processes were in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. However, not all these patients had a structured annual review to check that their health and care needs were being met.

Families, children and young people

Requires improvement

The practice was rated as good for caring overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe, effective, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments

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were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Requires improvement

The practice was rated as good for caring overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe, effective, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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

People whose circumstances may make them vulnerable

Requires improvement

The practice was rated as good for caring overall and this includes for this population group. The practice was rated as requires improvement in the domains of safe, effective, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of some groups of patients living in vulnerable circumstances including those with a learning disability. We saw no evidence of a formal system for reviewing patients whose circumstance may make them vulnerable within the previous year.

The practice worked infrequently with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice provided data at the time of inspection that showed that only 35% of patients at the practice on the register for experiencing poor mental health had received an annual physical

Summary of findings

health check. The practice had worked infrequently with multi-disciplinary teams in the case management of people experiencing dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including Healthy Minds. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Most staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection. All described the staff as respectful, helpful and compassionate. Patients told us they were involved in decisions about their care and treatment and that they were treated with dignity and respect. Six out of the seven patients stated it was difficult to get through to the practice on the telephone at times. Three commented that they found it easier to go to the practice in person rather than telephone for an appointment.

We collected four Care Quality Commission comment cards from a box left in the practice for two weeks before our visit. Most said they were happy with the service received when an appointment had been made. Three patients commented about their dissatisfaction on the frequent changing of the GPs. Two patients commented on an instance when a GP did not attend the practice to consult with the patients who had appointments booked.

Patient satisfaction with nursing staff at the practice was higher than the local average. We reviewed the latest GP national patient survey from July 2014 that showed 93% of practice respondents had confidence in the last nurse they had seen or spoke with. The clinical commissioning group (CCG) average was 88%.

The GP national patient survey of July 2014 reported patient satisfaction with telephone access and overall experience of making appointments was lower than other comparable practices in the area. For example, the GP national patient survey data showed that 49% of patients found it easy to get through to the practice by telephone, compared to the CCG average of 72%.

We spoke with representatives of the patient participation group (PPG), who were able to give us previous examples of when the PPG had suggested a positive change for patients at the practice. For example opening the telephone line earlier in the morning to help deal with the number of patients accessing the practice at that time. The PPG members had previously undertaken a patient satisfaction survey, highlighting positive points and areas for improvement. The PPG members told us they had not met with the practice since March 2014, as the practice had not called a meeting.

We also spoke with two members of staff from two different local care homes. Both members of staff said that a GP or nurse visited their setting on a weekly basis to review patients. They also commented that they could normally request a visit from a GP at other times if required. One of the staff members commented on that it often takes a long time to get through to the practice by telephone. The staff member also told us about a recent occasion when they had requested a GP to visit a patient who was unwell. They said that practice staff had told them there was not a GP available that day, as the GP had not attended for duty.

Areas for improvement

Action the service MUST take to improve

Improve the recording, investigation and dissemination of learning from significant events.

Regularly seek the views of patients using the practice.

Action the service SHOULD take to improve

Review policies and procedures to ensure they are current and in date.

Investigate the cause of higher than expected results in relation to antibiotic prescribing and amend practise if necessary.

Review the business continuity plan and mitigate risks.

Record minutes of meetings to assist in information sharing and activity governance.

Review patients identified on practice registers as needing higher level support.

Ensure that the method of complaint recording reflects all complaints received.

Understand and record the demographic ethnicity breakdown of all patients registered at the practice.

Ensure that telephone access for patients contacting the practice is fit for purpose.

Summary of findings

Review the arrangements for clinical leadership at the practice.

Packmoor Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor and a practice nurse specialist advisor.

Background to Packmoor Medical Centre

Packmoor Medical Centre is a general practice located in Stoke-on-Trent, Staffordshire. .

The practice has four locum GPs (three male and one female) currently contracted until March 2015, a practice manager, three practice nurses and one health care assistant. There is also a team of four receptionists and one secretary. There are almost 3500 registered patients at the practice. The practice is open from 8am to 6pm Monday to Friday and also provides a GP led clinic from 6pm to 8pm on a Tuesday and nurse led clinic from 6pm to 8pm on a Thursday.

The practice is in a modern spacious building and has occupied the present site for nearly 10 years. Patients of all age groups are registered and treated. The practice offers a range of services including review and management of long term conditions, NHS health checks, on site blood tests and travel immunisations. The practice also offers a contraceptive implant clinic by a visiting nurse on a monthly basis.

Packmoor Medical Centre has opted out of providing cover to patients outside of normal working hours. These out-of-hours services are provided by Staffordshire Doctors Urgent Care Limited.

The practice is operated by Network Healthcare Solutions Limited under an Alternative Provider Medical Services contract.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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.

How we carried out this inspection

To get to the heart of patients experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 December 2014. During our inspection we spoke with two GPs, the practice manager, an advanced nurse practitioner, a practice nurse, a healthcare assistant, two receptionists and three executive members of the provider company - Network Healthcare Solutions Ltd. We also contacted two local care homes and spoke with two members of the patient participation group (PPG). Members of the inspection team spoke in person with seven patients and reviewed four comment cards to seek the views and experience of people who used the practice.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The Staff we spoke with were aware of the process for raising concerns, near misses and reporting incidents. For example a concern was raised by a GP regarding an incident where a patient had attempted to contact a GP in time of crisis. The patient had telephoned the GP with urgent health needs and had not been offered an appointment or other means of access to a GP. We reviewed the form used to report this occurrence and saw that dates and times of submission were not entered. The incident had led to an investigation, which had suggested changes in operating practice. We saw that there were no significant event review dates in place. Reviewing significant events may minimise the risk of them occurring again and any actions implemented since the event could be tested to establish if they were robust. The senior members of staff were unable to provide us with evidence that reviews had been undertaken or that learning had occurred as a result. They said that all incidents were discussed at monthly clinical meetings held off site but minutes were not always taken.

We reviewed safety records and other incident reports There was some evidence that investigations had been undertaken and lessons learned. We looked at minutes which had been taken at some clinical meetings. We saw examples of discussions of patient safety incidents that had occurred. An example was a patient on medication who required annual blood tests. The patient had not had the required blood test for two years. Senior members of staff told us that they had acted on the information by investigating the incident, improving the process used and sharing learning with staff at the clinical meeting. We were unable to confirm this as the practice did not always take minutes at the clinical meetings.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. We saw that the system was not used consistently. Records were kept of some significant events that had occurred during the last 12 months and these were made available to us. We found that not all incidents that might affect patient safety were recorded or investigated. For example we saw evidence of an occasion when a locum GP booked to attend the practice to consult with patients had not attended due to illness. This occurrence left the practice with no GP cover on that occasion. We reviewed records that showed us this incident had not been recorded as a significant event, despite the impact this could have on patient safety. We reviewed records, including minutes of meetings, that included examples of events that might have compromised patient safety but these had not been recorded as significant events.

We reviewed the records of individual serious events available which demonstrated that some significant events had been investigated and changes made. For example, a missing histology sample (sample of body tissue requiring investigation in a laboratory) was recorded. Following the incident, the practice introduced a record book that required signatures to track samples to ensure they had left the practice with the courier

We saw incident forms were available on the practice intranet. We reviewed four completed forms. The records of significant events were filed by the date of occurrence. The medical director told us on completion of these forms, they were discussed at a monthly clinical meeting held at another practice.

The meeting involved clinical staff and practice managers from five practices as well as members of the executive team. The medical director told us formal minutes were not always taken. In the absence of minutes the practice did not provide us with assurance that learning from significant events had been discussed and shared with all relevant staff including locum GPs. We spoke with three members of nursing staff at the practice regarding the reporting process for significant events. All were able to detail the process but all could not recall a recent incident that had been discussed or learning shared

National patient safety alerts were received by all designated clinical staff at the practice. Staff we spoke with were able to give examples of alerts relevant to their area of practice. The alerts were emailed by the clinical director to appropriate staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We spoke with members of the medical, nursing and administrative

staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, record safeguarding concerns, and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and displayed on notice boards.

The practice had an appointed dedicated advanced nurse practitioner as a lead in safeguarding vulnerable adults and children. They had been trained to an appropriate level in safeguarding and could demonstrate they had the necessary knowledge to enable them to fulfil this role. The GPs at the practice had also been trained to an appropriate level in safeguarding. All of the staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

The practice had a separate policy for safeguarding both children and adults. We saw that both policies had been recently reviewed and were scheduled to be reviewed in the following year.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We saw computer records which provided an alert when a child was classed as 'at risk'. These alerts provided background information and highlighted protection plans in place to help keep children safe.

There was a chaperone policy which was visible on the waiting room noticeboard and in consulting rooms.. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, all receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a record book detailing daily checks on the fridge temperatures. We reviewed the policy for unexpected events.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

A practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurse and the health care assistant had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and they received updates in the specific clinical areas of expertise for which they prescribed. One nurse prescriber told us he could access support from a GP if he required it.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were kept securely at all times.

Infection Control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a recently appointed lead for infection control who needed to undertake further training to enable them to provide advice on the practice infection control policy and carry out staff training. The practice manager told us that the practice nurse would be receiving the training course within the next few months. All staff received induction training about infection control specific to their role and received annual updates. We saw an audit undertaken that year which encompassed different areas of the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy.

Requires improvement

Are services safe?

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice employed an external provider for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records which confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

All maintenance and risk assessments relating to the practice building were managed by a member of staff employed by the landlord. We saw records that showed that monthly and yearly building checks had been carried out and risk assessments made available.

We found the practice did not have robust arrangements for identifying, recording and managing all risks. The practice manager showed us the risk log, which formed part of the business continuity plan. We reviewed the practice business continuity plan; the document detailed a number of potential issues such as power failure and staff shortages. Key parts of information to minimise risks were not always detailed, although staff were able to tell us what they would do in the event. For example, staff told us if the power failed at the practice they would move the vaccines to a neighbouring practice owned by the company. The business continuity plan listed the loss of refrigeration for vaccines as a risk, although it did not mention the actions to take to prevent the loss of them. This could mean personnel following the plan may not relocate the vaccines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available at a secure central point. Equipment included oxygen therapy and nebulisation (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). There was also a pulse oximeter (to measure the level of oxygen in a patient's bloodstream). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were available in a lockable carry box within a secure central area of the practice. These were comprehensive and could be used to treat a wide range of medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a patient suffers a seizure/fit) and hypoglycaemia (a very low blood

sugar reading). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The staff we spoke with were all able to describe the action to take in the event of a patient becoming seriously unwell at the practice.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The management team told us new guidelines were discussed and disseminated at the monthly governance meeting and also by email. There was not a mechanism for relaying the information discussed to clinical staff who were not in attendance at the meeting. The medical director told us that another team member would do this, although he recognised the importance of keeping minutes and confirmed they would do this from now on. Nursing staff at the practice confirmed that NICE guidelines were discussed when meetings were held, although could not recall the time period of the last meeting they attended. We saw evidence that assessments of patients were undertaken with regard to NICE guidance.

We reviewed national data from NHS Business Services Authority (NHSBA) detailing the practice's performance for antibiotic prescribing. The data showed that the practice was reported to have issued nearly 50% more prescriptions for antibiotics per patient than the national average. The medical director told us he thought it was due to the high number of locum GPs used at the practice. We found no line of enquiry or audit had been undertaken to investigate the reasons. This meant that the practice was not effective in ensuring that patients were receiving the best possible treatment for their condition.

The practice identified patients with complex needs. We were shown care plans that demonstrated effective assessments for these patients had been undertaken. However current levels of review for groups of patients were below expected levels. For example the practice supplied data that showed 58% of patients with chronic obstructive pulmonary disease (COPD) had received an annual review in the last 12 months. One of the patients with a long-term condition we spoke with told us that they did not receive the invitation to attend for an annual review appointment this year as they normally would do. The practice supplied data also showed that 35% of patients at the practice on the register for experiencing poor mental health had received an annual physical health check.

Local data from the clinical commissioning group (CCG) showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen at a secondary care facility within two weeks.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice, all had a role in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management

The practice showed us two clinical audits that had been undertaken in the last year. Both of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. An example of this was an audit of patients referred to secondary care with suspected cancers. The audit revealed comparatively high referral rates in patients with suspected breast cancer. Following the audit best practice guidelines for referral had been shared with GPs. When the audit was revisited, referral rates had decreased with no detrimental effect on the safety of patients. The other audit concerned the referral of young children with acute illness to hospital. The audit tracked that the referrals were measured against best practice guidelines and found that all children had been referred correctly.

The practice also used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. In the previous year the practice had achieved a good QOF performance. For example, 92% of patients with diabetes had an annual medication review, and the practice had met all but one of the minimum standards for QOF in diabetes/asthma/COPD.

At the time of our inspection the recent departure of two regular GPs had impacted on the previous level of care provided to patients. For example, we reviewed the records of patients with a learning disability on the practice register, this amounted to seven patients. We saw no evidence in the records of the patients, of any being recalled for an

Requires improvement

Are services effective?

(for example, treatment is effective)

annual health assessment or medication review within the last 12 months. The practice manager told us that normally the practice was up to date with the reviews of patients. However as the two regular GPs had recently left the practice, they had fallen behind.

We were provided with practice data showed that 66% of patients on the register for dementia had been reviewed within the last year. Again staff told us that the recent loss of two GPs had impacted on the reviews of patients. The staff also told us that they were taking action to recall and review patients. We spoke with a newly appointed locum GP who confirmed they were involved in reviewing patients at annual checks.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

We saw that the practice had a palliative care register. Staff told us that they attended multidisciplinary meetings every three months to discuss the care and support needs of patients on the register and their families. The practice was only able to supply us with one set of minutes produced in the last year from these meetings. Staff at the practice told us that they have adopted the principles of the Gold Standard Framework (GSF). GSF promotes best care principles for patients who are nearing the end of their life.

The practice participated in local benchmarking programme run by the CCG. This involved a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other practices in the area. For example, we looked at outpatient referrals. These referrals were found to be broadly similar between all the practices in the benchmarking group.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending training courses such as annual basic life support training. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the practice manager had been developed through junior roles in the organisation and was subsequently funded to attend higher level education to underpin her knowledge and skills for the role.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles in treating patients with long term conditions such as COPD or asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified, appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs, including those with more complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

Requires improvement

Are services effective?

(for example, treatment is effective)

Staff told us the representatives from the practice attended multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions. However we were only provided with one set of minutes for the past year and so we were unable to determine the effectiveness of this process.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made all referrals that allowed this function last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios, where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

We were shown registers of patients who may experience difficulty in understanding proposed actions and communicating decisions, actions considered vital to the essence of consent. For example patients with a learning disability and those with dementia. Patients on those registers had care plans, which they were involved in agreeing. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all implantable contraceptive device procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. A healthcare assistant told us how patients were followed up promptly if they had risk factors for disease identified at the health check and how they scheduled further investigations.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice had identified the smoking status of 97% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. The practice targeted these clinics in the evening to maximise the opportunity for people to attend. .

The practice's performance for cervical smear uptake was 86%, which was better than others in the CCG area. There was a policy to offer telephone/text message reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG with almost all of the childhood immunisation rates at 100%. There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent GP national patient survey from July 2014. The practice supplied us with a copy of their most recent patient satisfaction survey. This survey had been undertaken 15 months before the date of inspection so could not be relied on to be the current opinion of patients at the practice.

The results from the GP national patient survey from July 2014 showed that although patient satisfaction rates had improved from the previous year, they remained broadly lower in most areas than the Clinical Commissioning Group (CCG) average.

We saw areas where the practice had scored higher than the regional average. For example, the practice was above average for its satisfaction scores on consultations with nurses with 88% of practice respondents saying the nurse was good at listening to them and 90% saying the nurse gave them enough time. We saw that 73% of patients described their overall experience at the practice as good This was lower than the regional average.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received four completed cards and most were positive about the caring nature of practice staff. Most patients commented they felt the practice GPs changed often which led to lack of continuity of care. We spoke with seven patients on the day of our inspection. All told us their dignity and privacy was respected at all times. Most of the patients we spoke with commented on the frequent change in GPs and felt this led to lack of continuity.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. We saw a notice in the waiting area requesting one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Staff showed us an area where patients could discuss confidential issues in private if required. One of the patients we spoke with confirmed that this facility had been offered when requested to discuss a confidential matter.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on where there had been incident in relation to privacy and dignity that showed the actions taken had been robust. There was also evidence of learning taking place as staff had attended customer service training in response to this incident.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

We reviewed the results of the GP national patient survey from July 2014 that showed patients' satisfaction rates to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice just below average in these areas. For example, data from the national patient survey showed 63% of practice respondents said the GP involved them in care decisions, this was slightly below the CCG average of 73%. Also 74% of patients at the practice felt the GP was good at explaining treatment and results, this was below the CCG average of 80%. We saw that patients rated their involvement in planning and making decisions with practice nurses highly. For example 88% of patients felt the nurse was good at listening to them, this was higher than the CCG average of 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment

Good

Are services caring?

they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. The majority of the comment cards we reviewed supported and aligned with those views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us about local support networks and gave examples of when a patient would be referred to them.

There was not a formal process in place for providing support to patients and their families who have suffered a recent bereavement. A GP told us that he would provide support as required and knew organisations to signpost patients to which could supply higher level emotional support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had a patient participation group (PPG). We spoke with two members of this group. Both confirmed that there had not been a PPG meeting since March 2014. The PPG members confirmed that the practice manager called meetings to discuss issues concerning the practice. They told us in the last eight months these meetings had not taken place. We were given an example of when a suggestion from the PPG was acted upon. This was following an internal patient survey in 2013 when following consultation with the PPG, the telephone line for the practice had been opened 30 minutes earlier to allow for the high volume of calls when the practice opened.

Tackling inequity and promoting equality

We reviewed practice held records that recorded the ethnicity of patients. The records we reviewed recorded an ethnic origin in less than 50% of the patients. Staff told us most patients registered were of White British origin. However this did not account for the remainder of patients whose ethnicity was not recorded. This meant the practice could not demonstrate that it was promoting equality for all patients as it did not understand the patient demographic.

Staff told us that they did not have a register of patients whose circumstances may make them vulnerable however would enable any patient to be seen if they presented at the practice.

We saw that the premises were situated on one floor with no steps making it easier for access for people with mobility issues. Doorways were wide and the waiting area was large which allowed for easy access to the treatment and consulting rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8am to 6pm Monday to Friday. The practice offered evening appointments with a GP 6pm to 8pm on a Tuesday and 6pm to 8pm with a practice nurse on Thursday. Staff showed us that patients could book appointments on the telephone, in person or online. Staff told us patients could opt in to receive reminders for by text message of an upcoming appointment. The practice also offered bookable telephone appointments for patients to consult on the telephone with a GP. Urgent same day appointments were available. We also looked at appointment availability for the four locum GPs, and all had routine appointments within three working days available some of these available the next day.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, the call was transferred to the out-of-hours provider.

Home visits were made by a GP or nurse to two local care homes on a specific day each week, and at other times when patients needed one.

Patients told us that they were generally dissatisfied with the telephone system for making appointments at the practice. The majority of patients we spoke with expressed difficulty in making telephone contact with the practice. Patients said telephone access was particularly difficult in the morning. We looked at the latest GP national patient survey from July 2014, which showed that 49% of patients found it easy to get through to the practice by telephone. The senior members of staff told us the telephone system was unable to accept more than one incoming telephone call at any time. This resulted in patients getting an engaged tone if someone else was calling the practice. We saw that this issue had been ongoing at the practice for some time. The operations director told us that the situation with the telephone system was challenging, as the parent company did not own the building and could not change the telephone system.

Patients we spoke with confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The NHS Constitution sets out individual patient rights and the accepted timescales in relation to complaint handling. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The practice made copies of the complaints procedure available at reception and also detailed the process on their website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We reviewed records of all complaints that had been recorded within the last 12 months, this amounted to four recorded complaints. We saw that in the minutes of a practice meeting, reference was made to six recent complaints concerning incorrect advice on appointments being given out. The practice manager told us that she tried to resolve complaints at the earliest opportunity to avoid the requirement for formal action. She told us about the action she had taken in relation to the incorrect advice being given by reception staff, this was by talking to the staff concerned

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear written vision to deliver high quality care and promote good outcomes for patients. These values were clearly displayed in the staff room and on the provider website. The practice vision and values included listed as quality, integrity, empowerment, responsibility, leadership, collaboration and innovation.

We spoke with five members of staff and they showed an understanding of the importance of improving patient care and knew what their responsibilities were in relation to this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures. Two out of the six policies and procedures we looked at had not been reviewed annually and were out of review date by a period of months.

There was a leadership structure in place. This structure placed the locum GPs under the management of the practice manager. We did not see evidence of a local clinic leadership structure for the practice clinicians and nursing staff. The GPs and advanced nurse practitioner we spoke with confirmed that there was not a formal method in place for monitoring their performance as far as they were aware. The operational director told us the nursing staff could go to the director of nursing and GPs to the medical director. These senior members of staff were based some distance away in another geographical area. We were also told about local monthly clinical meetings held which all clinical staff attended. However minutes were infrequently taken and the system had not prevented the underreporting of serious events or lack of recorded discussion and learning about patient care and safety.

The practice staff we spoke with felt well supported and they were all clear about their own roles and responsibilities. They all told us they felt well supported and could go to the practice manager with any concerns.

The practice used QOF to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data from the previous financial year 2013/2014 for this practice showed it was performing in line with national standards. The practice held data we reviewed that showed performance on the day of inspection showed that performance levels had fallen. For example, 58% of patients with COPD and had received an annual review and Senior members of the provider company told us QOF data was regularly discussed at monthly meetings and action plans were produced to maintain or improve outcomes. We were unable to confirm this happened as minutes of meetings were not taken.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with the practice manager if necessary.

Staff at the practice told us practice meetings happened infrequently. We saw some evidence in the two sets of minutes from practice meetings, that issues had been raised by practice staff and discussed.

The practice manager was responsible for human resource policies and procedures. We saw procedures and policies concerning equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

Staff supplied the latest survey performed by the patient participation group (PPG). This data had been collected 15 months before the date of inspection so could not be relied upon to be current. Staff also supplied us with results of the practice patient survey. This document was dated 9 December 2014, which was six days after the date of our inspection. The document stated that the survey was carried out in March 2013 which was nineteen months before the date of inspection. This evidence could not be relied upon to be the current views of patients registered at the practice.

The practice had not gathered internal feedback from patients during the last year. We saw no evidence that the practice had recently acted on the national patient survey or other means of feedback. Staff were unable to describe any changes which occurred recently. The executive team members from the provider company told us that they had actively been attempting to recruit a salaried GP to provide stability and to improve continuity of care as two GPs had

Are services well-led?

Requires improvement

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

recently left. They told us they had employed recruitment consultants and offered attractive incentives to attract a new GP, this had not been successful. We acknowledged that the recruitment of GPs was a recognised national issue. However the practice had failed to act upon other issues highlighted. For example poor national patient survey results on telephone access. The practice management team had no planned actions to improve telephone access as they did not own the building and said they could not change the telephone system.

We reviewed minutes of PPG meetings held in 2013 which demonstrated a committed and focused group of patients who had made valuable suggestions and contributed to improving care and access to the practice. The practice had not met with the PPG since March 2014 for reasons given by the management team were they were unable to do this due to high activity. We felt this was not an acceptable reason for not utilising the PPG.

The practice had a whistleblowing policy which was available electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and they had access to funding to attend external courses as well as those provided by the practice.

Most staff were unable to recall a significant event that had occurred within in the previous year or recall when they attended the last practice meeting. The practice management team told us that the clinical meetings occur monthly off site, however they were unable to supply us with any minutes to confirm this occurred or to corroborate issues such as significant events were discussed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that registered person had not ensured those who use services and others were protected against the risks of inappropriate or unsafe care and treatment because serious event investigation, recording and information sharing was not completed on all occasions. Significant events that been reported had not been revisited and reviewed to minimise the risk of reoccurrence. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not assessed, monitored and improved the quality of the experience of service users because they had not regularly sought the views of users receiving the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 ((1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.