Wearside Medical Practice

Quality Report

Pallion Health Centre,
Hylton Road,
Sunderland, SR4 7XF
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Date of inspection visit: 6 November 2017
Date of publication: 01/01/2018

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

Ratings

Overall rating for this service	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated requires improvement overall. We have limited this rating, in line with our principles of aggregation, because there is an underlying rating of inadequate in one of the key questions.

The key question we inspected is rated as:

Are services well-led? - Inadequate

We first carried out an announced comprehensive inspection of this practice on 31 August 2016. We rated the practice then as good overall and requiring improvement for providing well-led care. This was because although the practice had some governance arrangements in place, there were areas that needed improvement.

We carried out this announced focused inspection at Wearside Medical Practice on 6 November 2017 to check whether the practice had followed their action plan and taken steps to comply with legal requirements. The practice had submitted an action plan, which showed they planned to address the concerns by 31 March 2017. This inspection focused on the key question – is the practice well led.

We rated the practice as requires improvement overall.

At this inspection we found:

- The lack of leadership and oversight in the practice resulted in ineffective systems to identify and proactively manage risks, issues and performance.
- There was a lack of shared vision within the partnership. The practice did not have effective strategies in place to make sustainable improvements.
- The practice overarching governance framework was not effective and did not support the practice to identify and act upon areas for improvement. The practice had not made sufficient improvements in many of the areas identified by CQC previously. This included their approach to audit, the process for reviewing and updating policies and procedures, organisation of staff records and the process for reviewing trends and themes of significant events.
- Improvement was not a priority among staff and leaders.

At the 31 August 2016 inspection, we said the practice should ensure there were systems and processes in place to identify and meet the needs of carers. In November 2017, we found the number of carers had increased from 0.4% (29 carers) to 0.6% (46 carers). However, this was still lower than expected given the demongraphics of the practice population. The 2011 census data for the local authority area indicated that 11.8% of patients provided some level of unpaid care.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

Summary of findings

- Ensure there are systems and processes in place to identify and meet the needs of carers.

Where a service is rated as inadequate for one of the five key questions or one of the six population groups, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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

Wearside Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector.

Background to Wearside Medical Practice

Wearside Medical Practice is registered with the Care Quality Commission (CQC) to provide primary care services.

The practice provides services to just over 7,500 patients from one location, Wearside Medical Practice, Pallion Health Centre, Hylton Road, Sunderland, SR4 7XF, which we visited as part of this inspection.

Wearside Medical practice is a medium sized practice providing care and treatment to patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of the NHS Sunderland clinical commissioning group (CCG).

Information taken from Public Health England placed the area in which the practice is located in the third most deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The average male life expectancy is 76 years, which is three years lower than the England average and the average female life expectancy is 81 years, which is two years lower than the England average.

The practice has two GP partners, of which one is male and one female. There are also two salaried GPs (both female), a practice manager, a nurse prescriber (female) and two practice nurses (female), two healthcare assistant apprentices and eight administrative support staff.

The practice is open between 7am to 6pm Monday to Friday. Appointments are normally available between 7am to 11:30am and 2pm to 6pm, dependent on staff availability and clinical sessions worked. Reception services are available from 7:00am to 6pm Monday to Friday. There is a local contract with the 111 service to provide telephone cover between 6 to 6:30pm.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Vocare Limited, known locally as Northern Doctors Urgent Care (NDUC).

Why we carried out this inspection

We undertook a comprehensive inspection of Wearside Medical Practice on 31 August 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We rated the practice then as good overall and requiring improvement for providing well-led care. There was a breach of regulatory requirements.

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

We carried out this announced follow up focused inspection on 6 November 2017 to check whether the practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 31 August 2016, we rated the practice as requires improvement for providing well-led services as we found although the practice had some governance arrangements in place, there were areas that needed improvement. This included their approach to audit, the process for reviewing and updating policies and procedures, organisation of staff records and the process for reviewing trends and themes of significant events.

We issued a requirement notice in respect of these issues and found arrangements had not improved when we undertook a follow up inspection of the service on 6 November 2017. We have now rated the practice and all of the population groups as inadequate for being well led.

The practice was rated as inadequate because:

- The lack of leadership and oversight in the practice resulted in ineffective systems to identify and proactively manage risks, issues and performance.
- There was a lack of shared vision within the partnership. The practice did not have effective strategies in place to make sustainable improvements.
- The practice overarching governance framework was not effective and did not support the practice to identify and act upon areas for improvement. The practice had not made sufficient improvements in many of the areas identified by CQC previously.

Leadership capacity and capability

We found the capacity for leadership had deteriorated since the previous inspection in August 2016. One partner was on extended leave and the date for them to return was unknown. The lack of leadership and oversight in the practice resulted in ineffective systems to identify and proactively manage risks, issues and performance. The leadership arrangements did not support the practice to improve.

Leaders did not demonstrate sufficient capability to understand their regulatory responsibilities. They did not understand their responsibilities to operate effective systems and processes to assess and monitor how the service met regulatory responsibilities. As they did not effectively monitor progress against plans to improve the quality and safety of services; they did not identify where progress was not made as expected and did not take remedial action to address the concerns in a timely way.

The practice did not have processes to develop leadership capacity and skills. They were not effectively planning for future leadership of the practice. The partnership had decreased from four partners when they first registered in April 2013, to two partners. Although they had identified the need to increase the membership of the partnership, this had been hindered by the absence of one of the partners. An agreement had just been reached to seek additional partners, but plans were at an early stage.

The local Clinical Commissioning Group (CCG) had been called in to intervene in discussions between partners, when they were unable to come to an agreement about how the partnership should operate. This had led to a temporary agreement. However, as this had taken place the week before the inspection, it was too early to see if this was effective.

The practice did not have a CQC registered manager and had not done so since 6 December 2016. This is a breach of their conditions of registration. We are taking separate action to follow up this breach with the provider.

Vision and strategy

We found there was a lack of shared vision within the partnership. The practice did not have effective strategies in place to improve the service.

In August 2016, we found the practice had an informal strategy, and had not developed supporting business plans. At this inspection, we found the practice still did not have a business plan in place. Alongside the lack of shared vision in the partnership, this had operated as a barrier in planning for and making the necessary improvements identified at the previous inspection.

Governance arrangements

The practice's overarching governance framework was not effective and did not support the practice to identify and act upon areas for improvement. This put the delivery of an effective strategy and provision of good quality care at risk. The practice did not have a comprehensive understanding of their own performance.

In August 2016, although we rated the practice as good overall, we rated them as requires improvement for providing well-led services. We found although the practice had some governance arrangements in place, there were areas that needed improvement. This included their approach to audit, the process for reviewing and updating policies and procedures, organisation of staff records and

Are services well-led?

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the process for reviewing trends and themes of significant events. At the November 2017 inspection, we found the practice had not made sufficient improvements in many of the areas identified by CQC previously. This placed patients at risk of receiving services, which were not monitored for quality, safety and effectiveness. For example,

- It was still not clear how the practice used audit to demonstrate quality improvement. The selections of topics for audit were generated by individual clinician areas of interest and the practice had not considered how they could use audit to support them to improve as a practice.
- Although practice specific policies were available, the practice did not have a clear process in place for reviewing and updating these. For example, the practice policy on the Mental Capacity Act 2005 which we found in August 2016 was last reviewed in April 2014, had still not been reviewed or updated. They were due to review their Infection control policies in November 2016 and this had not happened.
- The practice still did not have a process in place to review trends and themes of significant events to reduce the risk of repeating them.
- Staff records were still disorganised.
- Staff were able to demonstrate the process they had followed to manage patient safety alerts. However, the associated audit trail for this was out of date. The practice had to pull this information from several different sources to demonstrate the action they had taken. The practice did not have an effective check process in place to make sure they took appropriate action in a timely way.
- The practice had not undertaken an audit to assure themselves of the effectiveness of their infection control arrangements since April 2016.
- The practice still did not maintain a record of the immunisation status of staff to help assess and manage the risk of cross infection within the workplace. The practice had repeated the exercise to ask staff for this information but no-one had responded and they took no action to follow this up.

We asked the practice to provide the following information both during the inspection, and after the inspection. However, they did not send this to us:

- A summary of the last six months of significant events they had raised ,
- An example of a completed significant event analysis they had discussed with us during the inspection
- An infection control audit, if they had undertaken this within the last year.

This demonstrated practice leaders did not have insight into their legal responsibilities to provide evidence on how they comply with the regulations.

Managing risks, issues and performance

There were some areas where the practice had made improvements:

- The practice had improved their governance processes for managing performance against national indicators. This had resulted in improved outcomes for patients. The most recent published Quality Outcome Framework (QOF) showed continuous and sustained improvement. (The practice had achieved 82.4% of the overall points available in 2014/15. In 2015/16, this had increased to 95.4% (CCG was 95.8% and England 95.3%). They sustained this improvement in 2016/17, with 95.9% of the points available. (CCG was 96.4% and England 95.5%.) However, the exception reporting in 2016/17 was 17%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) This was much higher than the CCG average of 11.1% and national average of 9.9. It was also much higher than the exception rate in 2014/15, which was 5.6%.
- The practice had improved their assurance processes for implementing clinical guidance. At the last inspection we found the practice had not assured themselves that clinical staff had read and understood new NICE guidance and other guidelines. They were not routinely discussed at clinical meetings. There was now evidence the practice discussed NICE and other national guidelines at clinical meetings.

Continuous improvement and innovation

There was little evidence of learning or reflective working across the way the practice operated. The practice did not have effective processes in place to learn from significant events and clinical audits. We found development and improvement was not a priority among leaders and staff.

This section is primarily information for the provider

Enforcement actions

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The systems or processes in place were not operating effectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • The programme of continuous clinical and internal audit in use was not effective at monitoring quality and supporting the practice to make improvements. • The practice had not considered how they could use audit to support them to improve as a practice. They had not undertaken an audit to assure themselves of the effectiveness of their infection control arrangements within the last year. • The audit trail for the management of patient safety alerts did not help the practice identify and follow up the actions they needed to take to keep patients safe. • The practice did not review trends and themes of significant events. **There was additional evidence of poor governance. In particular:** • The current leadership arrangements and management structure placed the practice at risk of being unable to make the necessary improvements required. • The practice had failed to take reasonable steps to address some of the concerns identified at the previous CQC inspection. • Although practice specific policies were available, the practice did not have a clear process in place for reviewing and updating these. **This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **We have issued a warning notice in relation to this breach.**