Spring Terrace Health Centre

Quality Report

The Health Centre, Spring Terrace, North Shields,
Tyne and Wear, NE29 0HQ
Tel: 0191 296 1588
Website: www.springterrace.co.uk

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Spring Terrace Health Centre on 10 March 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective and responsive services and for being well-led. Improvements were also required to ensure caring services are provided.

- Risks to patients were not minimised sufficiently because some systems and processes were not in place to keep them safe, for example, there was no health and safety risk assessment and staff had not received fire training. Staff were clear about reporting incidents, near misses and concerns but they did not receive any outcomes or learning from this.
- There were systems in place to monitor infection control and medicines were managed effectively.
- There was a limited amount of clinical audits in place to improve patient outcomes or systems for learning. Some patients who had long term conditions or were on the practice's mental health register had not received an annual health check. There were gaps in the management of training for staff.
- Data showed patient outcomes were in line or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. We saw good evidence of multi-disciplinary team working.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients said however sometimes they found staff talked loudly at the reception window and felt their privacy could be compromised.
- Patients reported difficulty in obtaining appointments. Patients and staff said one of the main problems was not being able to book appointments in advance. Patients we spoke with told us and staff confirmed there was a queue of patients outside the practice every morning to ensure they could obtain an appointment.

Summary of findings

- There were high numbers of complaints which mostly referred to the appointment system and patients being unable to obtain an appointment.
- The practice had good facilities and was equipped to treat patients.
- Although there was a formal leadership structure the arrangements for governance and performance did not operate effectively.

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

Importantly, the provider must:

- Ensure systems and processes are established and operated effectively in order to assess, monitor and improve the quality of service provided in carrying out the regulated activities.
- Ensure risks are effectively assessed, monitored and mitigated in relation to the health, safety and welfare of patients receiving care and treatment in relation to patients being able to obtain a consultation with a healthcare professional.
- Ensure records which are necessary to be kept in relation to staff and management of the regulated activities are maintained.
- Ensure they have a formal system for clinical audit which improves quality.
- Ensure staff receive appropriate training in order to carry out the duties they perform.
- Ensure that they can demonstrate that Healthcare professionals continue to meet professional standards which are a condition of their ability to practice or a requirement of their role.

The provider should;

- Document a clear rationale in their staff files as to why a DBS check was not appropriate for non-clinical staff.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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?

Inadequate

The practice is rated as inadequate for safe and improvements must be made. Staff were clear about reporting incidents, near misses and concerns but they did not receive any feedback on the outcome of any investigations. Patients were at risk of harm because some systems and processes were not in place to keep them safe, for example, there was no health and safety risk assessment and staff had not received fire training. Recruitment processes were not effective and we did not see evidence of checks on clinician's professional qualifications or medical indemnity insurance. There were systems in place to monitor infection control and medicines were managed effectively.

Are services effective?

Inadequate

The practice is rated as inadequate for effective and improvements must be made. There was a limited amount of clinical audits taking place to improve patient outcomes or systems for learning. Some patients who had long term conditions or were on the practice's mental health register had not received an annual health check. There were gaps in the management of training for staff. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. We saw good evidence of multi-disciplinary team working.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Data showed that patients rated the practice as being in line with 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. We also saw that staff were considerate with patients, treated them with understanding. Patients said however sometimes they found staff talked loudly at the reception window and patients felt their privacy could be compromised.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services and improvements must be made. Patients reported difficulty in obtaining appointments. Patients and staff said one of the main problems was not being able to book appointments in advance. There was a rush by patients both on the telephone and at the reception desk once appointments were released at 8:15am every day. The practice responded to complaints; however they did not

Summary of findings

have an up to date complaints policy. There were high numbers of complaints which mostly referred to the appointment system and patients being unable to obtain an appointment. The practice had good facilities and was equipped to treat patients.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made. There was no vision or values statement for the practice. However they had identified some shortfalls in their performance. The governance arrangements did not always operate effectively. There were policies and procedures in place, although these were not up to date.

There was a leadership structure and some staff felt supported by managers, some staff told us they were frustrated with the appointment system and it was difficult dealing with dissatisfied patients. Governance meetings were held but minutes of some of these meetings were not maintained. The practice proactively sought feedback from patients and had a patient participation group (PPG). Staff felt that communication was not strong within the practice and their views were not taken into account.

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

Inadequate

The practice is rated as inadequate overall for the care of elderly patients. There were aspects of the practice which were inadequate and related to all population groups. The practice offered proactive, personalised care to meet the needs of the older people in its population for example; Patients who were aged over 75 had a named GP. The daily on-call GP gave priority for follow up for the elderly and high risk patients.

There were care plans in place for 2% of patients with complex conditions, which included frail elderly patients. The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

People with long term conditions

Inadequate

The practice is rated as inadequate overall for the care of people with long-term conditions. There were aspects of the practice which were inadequate and related to all population groups. The practice identified patients with long-term conditions who needed additional support. There were GP clinical leads for areas such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. Health checks for these patients had been linked to medication reviews, the practice had identified that this had not worked well and in the future a dedicated administration member of staff was to send for the patient for a review in their birthday month.

Families, children and young people

Inadequate

The practice is rated as inadequate overall for the care of families, children and young people. There were aspects of the practice which were inadequate related to all population groups.

The practice offered baby and ante-natal clinics. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. The practice offered routine immunisations for babies and children under five, during clinic appointments. Data showed that the number of children receiving the vaccines was in line with or above the clinical commissioning group (CCG) average. For example, with regard to nine of the ten childhood immunisations for children aged five years, the numbers who received these were above the local CCG averages.

Every month the practice held a meeting with the health visitor, the agenda included children which were registered at the practice who were subject to protection plans.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for working age people (including those recently retired). Patients who were working had difficulty making an appointment. Most of the comments from the practice's own patient survey referred to patients being unable to book an appointment easily and these comments particularly came from working patients. Early morning appointments for working patients which were advertised in the patient information leaflet had not been in operation for three to four weeks prior to our inspection. The practice offered a range of clinics; these included counselling, smoking cessation, minor surgery, travel vaccinations, contraceptive advice and cervical screening.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate overall for the care of people whose circumstances may make them vulnerable. There were aspects of the practice which were inadequate and related to all population groups.

The practice had registers of patients in vulnerable circumstances which included patients with learning disabilities. There were 51 patients on the register, only 74.5% of these patients (38) had received an annual health check.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate overall for the care of people experiencing poor mental health (including people with dementia). There were aspects of the practice which were inadequate and related to all population groups.

The practice had care plans in place for patients experiencing poor mental health and they received an annual review. The practice supported them in conjunction with the community mental health team.

Dementia screening was undertaken and patients would be followed up with a referral to the memory clinic.

Summary of findings

What people who use the service say

We spoke with seven patients during the inspection, including a member of the Patient Participation Group (PPG). Patients told us they were happy with the care they received. All of the seven patients we spoke with raised issues with the appointment system. Patients felt the system was unsatisfactory, they told us there was a rush at 8:15am on a morning for patients either on the telephone or queueing in person at the surgery to secure appointments. Two of the patients we spoke with said the reception staff were unhelpful. Three patients said there was a problem with confidentiality at the reception desk. Patients said staff talked loudly at the window and they felt their privacy could be compromised.

We reviewed 24 CQC comment cards completed by patients prior to the inspection. Six patients commented on the reception staff being polite, patient and helpful. Eight of the comment cards raised issue with the appointment system and the ability to get through to the practice on the telephone. Words used to describe the appointment system included unrealistic, poor and difficult.

The latest GP Patient Survey completed in 2013/14 showed that patient satisfaction was below the national averages. The results were:

- Percentage of patients who would recommend the practice – 71.4% (national average 79.1%);
- Percentage of patients satisfied with phone access – 62.1% (national average 75.4%);
- GP Patient Survey satisfaction for opening hours – 77.7% (national average 79.9%).

The practice carried out its own survey in June and July 2013. From this 95% of patients found the reception staff friendly and helpful. 70% of patients were happy with their contact with the surgery. 51% of patients found it fairly easy to make an appointment, 30% not very easy and 11% very easy. Most of the comments referred to patients being unable to book an appointment easily, particularly comments from working patients.

Areas for improvement

Action the service MUST take to improve

Importantly, the provider must:

- Ensure systems and processes are established and operated effectively in order to assess, monitor and improve the quality of service provided in carrying out the regulated activities.
- Ensure risks are effectively assessed, monitored and mitigated in relation to the health, safety and welfare of patients receiving care and treatment in relation to patients being able to obtain a consultation with a healthcare professional.
- Ensure records which are necessary to be kept in relation to staff and management of the regulated activities are maintained.
- Ensure they have a formal system for clinical audit which improves quality.
- Ensure staff receive appropriate training in order to carry out the duties they perform.
- Ensure that they can demonstrate that Healthcare professionals continue to meet professional standards which are a condition of their ability to practice or a requirement of their role.

Action the service SHOULD take to improve

- Document a clear rationale in their staff files as to why a DBS check was not appropriate for non-clinical staff.

Spring Terrace Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, and a specialist advisor with experience of GP practice management.

Background to Spring Terrace Health Centre

The area covered by Spring Terrace Health Centre is primarily North Shields, Tynemouth, Cullercoats and Percy Main which are the NE29 and NE30 postcode areas. The surgery building is located close to the centre of North Shields.

The practice has four GPs partners and two salaried GPs. Some of the GPs work part time. The whole time equivalent is 4.37 GPs. All are female. The practice is a training practice. There are two practice nurses and one health care assistant. There is a business manager, office manager assistant manager, practice pharmacist, reception and administrative staff.

The practice provides services to approximately 7,000 patients of all ages. The practice list size had decreased by approximately 1,500 patients in the last few years. The practice is commissioned to provide services within a General Medical Services (GMS) Agreement with NHS England.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Northern Doctors Urgent Care.

Why we carried out this inspection

We inspected this service as part of our 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.

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?

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)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and NHS England.

We carried out an announced visit on 10 March 2015. During our visit we spoke with a range of staff. This included GPs, practice nurses and reception and administrative staff. We also spoke with seven patients. We reviewed 24 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

As part of our planning we looked at a range of information available about the practice from the General Practice Outcome Standards (GPOS), National GP patient survey and the Quality Outcomes Framework (QOF), which is a national performance measurement tool. The latest information available to us indicated there were some areas of risk in relation to patient safety. On the day of the inspection the practice were unable to demonstrate they had a safe track record.

We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. However, systems and processes to address safety risks such as fire were not fully embedded enough to ensure patients were kept safe, for example, staff had not received health and safety or fire safety training. The practice could therefore not demonstrate a consistent safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were discussed at weekly partners meetings and monthly team meetings.

There were records of significant events captured in minutes of a yearly meeting to review complaints and significant events. There were eight documented and discussed which covered the last 12 months.

Where incidents and events met the threshold criteria, these were also added to the local CCG Safeguard Incident & Risk Management System (SIRMS). This allowed the practice to contribute to, and benefit from, learning identified from incidents across the local area and also to share information where more than one organisation was involved.

We asked staff about the significant event procedure. They could explain their responsibilities in the reporting process; however they did not receive any feedback or receive any learning as a result of the incidents reported.

National patient safety alerts were disseminated either by email or paper copy depending upon how they were received by the practice. We were told paper copy alerts had a cover sheet on them and staff signed and dated when they read. We raised concerns about the audit trail the practice had and how they could be reassured that these were being seen by the necessary staff. The practice said they would look at how they could improve the process for ensuring staff saw and acted on the relevant safety alerts.

Reliable safety systems and processes including safeguarding

The practice had a dedicated GP each for safeguarding children and safeguarding adults. We were told all of the GPs working in the practice been trained to level 3 for safeguarding children, however we only saw one training certificate. We were unable to evidence this level of training for the other GPs. We saw the practice had safeguarding adults and children policies. Every month the practice held a meeting with the health visitor, the agenda included children which were registered at the practice who were subject to protection plans. We were unable to see minutes of these meetings however were told that the health visitor had records of the notes of the meetings.

Staff we spoke with had knowledge of safeguarding and the procedures to follow if they encountered any concerns. Staff said they had received safeguarding training. There was one member of staff who had recently been recruited the month before who had not yet received this training. Training records included copies of the certificates, which showed staff had received safeguarding children and adults training.

The practice had a chaperone policy. However, this was undated and did not have a review date. The policy recommended that clinical staff should carry out chaperoning. It said that non clinical staff who felt comfortable with the role could assist with the patient's permission. The policy did not set out training requirements for non-clinical staff who acted as chaperone. The policy did not set out the need for staff to have received a disclosure and barring check (DBS) if they were left alone with a patient. We were told it was rare that non clinical staff were used as chaperone, but those that did had been trained. None of the staff we spoke with had carried out this role. Training records did not include any details of chaperone training. There were no notices displayed in the patient waiting area to inform patients of their right to request a chaperone.

Inadequate

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. We saw that medicines in vaccine refrigerators were kept at the required temperatures.

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. Blank prescription forms were handled according to national guidelines and were kept securely.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

The practice had a pharmacist who was employed by the clinical commissioning group and supported the practice part time. They held a minor ailment clinic one morning a week. The pharmacist disseminated changes to medicine prescribing to staff and they were involved in the reviewing and issuing of repeat prescriptions.

Cleanliness and infection control

We saw the practice was clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

One of the practice nurses was the nominated infection control lead. We saw there was an infection control policy; however the policy had not been updated since 2009. There was an infection control checklist which had been completed by a member of reception staff in February 2015.

The staff training matrix showed infection control as compulsory training for staff however, the only staff member shown to have received training was the senior receptionist who had carried out the infection control checklist. There was no infection control training shown for the practice nurse who was the infection control lead.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that were easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable and had the date written on them when they were last changed. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

Part of the service the practice received from the landlord included the domestic cleaning of the practice. We saw there were cleaning schedules for daily weekly and monthly cleaning and the practice made regular checks to ensure these were being followed.

We saw a legionella (bacteria found in the environment which can contaminate water systems in buildings) risk assessment had been carried out for the practice.

Equipment

Staff 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. We saw evidence of the calibration of relevant equipment; for example, weighing scales and blood pressure machines displayed stickers indicating when the next testing date was due.

Staffing and recruitment

The practice maintained a recruitment staffing folder this contained a recruitment policy which was not dated, we could therefore not be sure it had the updated changes to legislation included in it. There were other policies including confidentiality, appraisals and lone working policy. Some dated back to 2007; none of the policies had been reviewed since 2012.

We looked at a selection of staff recruitment files. We saw in all staff files regardless of when they had been recruited there were evidence of identity checks such as a passport or driving license. In the case of the two most recently recruited members of staff, who were recruited in 2014 and 2015, there was one reference for one member of staff and none for the other, we were told references had been taken up but they were not on file.

Inadequate

Are services safe?

We were told that there were disclosure and barring checks (DBS) for clinical staff and those staff who had been recruited after April 2013. However some staff who were recruited prior to April 2013 did not have a DBS check. There was no clear rationale in their staff files as to why a DBS check was not appropriate.

There were no checks in staff files of the professional registration status of GPs and practice nurses (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)) each year to make sure they were still fit to practice, the practice was not checking this. We asked for evidence of medical indemnity insurance for all clinicians employed at the practice however this was not provided to us on the day of our inspection staff said these were held but not by them and the GP who had access to them was not at work that day.

We asked how the practice monitored if there were enough staff on duty to ensure patients were kept safe. We were told that a GP partner ensured there were enough GPs on duty. Practice nurse and administration cover was organised by the office manager. The practice were currently recruiting clinical staff.

The practice used locum cover, there was a service level agreement in place with a locum agency if they needed to be used. There was a salaried GP/locum induction checklist for new members of staff.

Monitoring safety and responding to risk

We asked to see the practice's health and safety risk policy. We were given a document which was a statement of intention, not a policy, it was not dated nor did it have a review date. The practice did not have a health and safety risk assessment. Staff had not received health and safety training although it was shown as compulsory on the staff training matrix.

The building was privately owned and maintained by NHS property services. Staff told us that this arrangement worked well and there were no problems with maintenance being carried out.

Arrangements to deal with emergencies and major incidents

The staff training records showed that staff had received training in basic life support; there was evidence of certificates documenting this in the staff files we looked at. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew where this equipment was kept and confirmed they were trained to use it. They also showed us the emergency medicines and all staff knew of their location. 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.

We saw a business continuity plan was in place to deal with emergencies that may impact on the daily operation of the practice. However this was not dated, it could therefore not be established if for example the contact information in this was still current.

There was a fire risk assessment which was not practice specific this was dated August 2012. The staff training matrix showed that fire safety training was compulsory. However, the dates for this were blank and there were no fire safety training certificates in staff files. Staff told us they had not received fire safety training. Staff told us there were fire wardens. However there were no details of these in the fire risk assessment and no evidence of training for this role. Staff told us they had a fire drill the week before our inspection. We were unable to confirm if there were weekly tests of the fire equipment on the day of the inspection. These records were supplied to us after the inspection.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could outline the rationale for their treatment approaches. We were told patient safety alerts and guidelines from the National Institute for Health and Care Excellence (NICE) were discussed at clinical meetings to enable shared learning. The pharmacist attached to the practice provided updates on medicines.

We were told by one of the GP partners that there were care plans for only 2% of patients with complex conditions, we asked to see an example which the GP showed us although this took some time to locate. This included patients with learning disabilities, enduring mental health problems, frail elderly patients and frequent hospital attenders. There were alerts on the practice computer system to alert staff that they had a care plan. The list of patients were discussed along with patients who required palliative care at monthly multi-disciplinary team meetings. The practice were participating in an enhanced service (which is a service other than an essential service), for avoidance of unplanned admissions of patients to hospital.

All those over the age of 75 had a named GP. The practice identified patients who needed additional support, for example, patients with long term conditions. There were GP clinical leads for areas such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. Health checks for these patients had been linked to medication reviews; the practice had identified that this had not worked well and in the future a dedicated administration member of staff was to send for the patient for a review in their birthday month. The practice found that patients often did not attend reviews. They said this was possibly linked to difficulty in accessing appointments.

The practice had registers of patients in vulnerable circumstances which included patients with learning disabilities. There were 51 patients on the register, only 74.5% of these patients (38) had received an annual health check. There were 57 patients on the mental health register where only 64.7% (33) patients had received a review in the last year. Dementia screening was undertaken and patients would be followed up with a referral to the memory clinic.

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

The practice did not use audits effectively to improve quality. On the day of our inspection the practice could not provide evidence that there was a formal system for clinical audit. They provided us with two audits, these were from 2012/13 and 2014/15.

Prior to the inspection the practice were asked to provide us with evidence of clinical audit cycles carried out in the last 12 months. One audit which was sent to us was carried out in the last twelve months was an audit of a medicine used to treat depression. NICE guidance also recommended that the medicine should no longer be used. The two cycle audit reduced the number of patients taking the medicine from 13 to two. The two patients who were still prescribed the medicine were being prescribed the medicine by secondary care clinicians. The other audit which was sent to us related to atrial fibrillation, a heart rhythm disorder, which was carried out in August 2012 and re-audited in 2013.

We asked a GP partner about clinical audit on the day of the inspection and they told us that clinical audits were carried out and supplied as needed for GP appraisal. However the GPs found it difficult to find time to carry out formal audits and complete audit cycles were not carried out.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had achieved a score of 93.6%, which was below the average in England which was 94.2%. A GP partner told us that QOF was used by the practice to audit quality improvement.

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. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

We asked for evidence of staff training carried out in the last three years prior to the inspection. We were provided with an excel spreadsheet which was a record of compulsory training for all staff at the practice. There were gaps in the spreadsheet and the business manager confirmed staff had not received the training where the spread sheet did not contain a date. This included training for health and safety, fire training, infection control, information governance and mental capacity act training. Staff we spoke with confirmed they had received CPR and safeguarding training and the dates were included in the spreadsheet.

The excel spreadsheet provided by the practice prior to the inspection also contained a record of staff appraisals. There were entries, within the last year, on the spreadsheet for when administration staff and practice nurses had received an appraisal. We saw in three out of four staff files that an appraisal was held for the members of staff. The salaried GPs were not included on the spreadsheet and there was no evidence of developmental review from the practice in their staff file.

The GPs we spoke with 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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.).

We looked in the files of the two most recent members of staff who had been recruited in 2014 and 2015. We were told that staff received an induction; however there was no documented evidence of an induction when they began to work at the practice.

Working with colleagues and other services

The practice had good working arrangements with other health and social care providers, to co-ordinate care and meet people's needs. There were multidisciplinary team meetings every Wednesday on a rotation basis, for example one a month would be a safeguarding meeting then the next a palliative care meeting. These meetings included GPs, practice nurses, district nurses and health visitors.

Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the patient's referring GP and the duty doctor. We saw the practice computer system was used effectively to log and progress any necessary actions.

Information sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals using 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).

There was a protocol in place to review emails from the out of hours provider and also for hospital discharge information.

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff were able to give examples of how they obtained verbal or implied consent. We saw a consent to treatment form which the practice used for consent to investigations or invasive treatment.

A GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Inadequate

Are services effective?

(for example, treatment is effective)

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We were told staff had received training on the MCA, although this did not correspond with training records which we saw. We found the GPs were aware of the MCA and used it appropriately. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

New patients were able to download a pre-registration form and a medical questionnaire from the practice website or call in in person to complete the form. The practice would offer a health check dependent upon the patient's circumstances. Patients could request a health check if they wanted one.

The practice offered a range of clinics; these included counselling, smoking cessation, minor surgery, travel vaccinations, contraceptive advice and cervical screening.

The QOF data for 2013/14 confirmed the practice obtained 89% of the total points available for supporting patients to stop smoking, this was 6 points below the local CCG average and 4.7 points below the England average, using a strategy that included the provision of suitable information and appropriate therapy. The data also showed the practice had obtained 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages. The practice had also obtained 96.5% of the points available to them for providing cervical screening to women from QOF. This was 3 percentage points below the local CCG average and 1 point below the England average. The rate of take up for cervical screening for women aged 25-64 in the last five years was 76% (England average 77% and CCG average 79%).

The practice offered baby and ante-natal clinics. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. The practice offered routine immunisations for babies and children under five, during clinic appointments. Last year's performance for immunisations was below averages for the Clinical Commissioning Group (CCG). For example, infant meningococcal C (Men C) vaccination rates for two year old children were 95.2% compared to 96.8% across the CCG; and for five year old children were 88.3% compared to 92.1% across the CCG.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from the national GP patient survey 2013/14 The data showed that the proportion of patients who described their overall experience of the GP surgery as good or very good was 85.3%; this was in line with the England average which is 85.7%. The proportion of patients who said their GP was good or very good at treating them with care and concern was 84.9%, the England average is 85.3%. The proportion of patients who said the nurse was good or very good at treating them with care and concern was 89.7%, the England average is 90.4%.

The practice carried out its own survey in June and July 2013. From this 95% found the reception staff friendly and helpful. 70% of patients were happy with their contact with the surgery

We reviewed 24 CQC comment cards completed by patients prior to the inspection. Six patients commented on the reception staff being polite, patient and helpful.

We spoke with seven patients during our inspection, they told us they were happy with the care they received. Two of the patients we spoke with said the reception staff were unhelpful.

We were told by staff that if patients could not obtain an appointment at the practice they were told that they could attend the local walk-in centre. The standard response to complaints in relation to patients being unable to obtain an appointment included a sentence that they could attend the local walk in centre.

Three of the patients we spoke with said there was a problem with confidentiality at the reception desk. The window to the reception area where the reception staff were, faced into the waiting room. Patients said staff talked loudly at the window and patients felt their privacy could be compromised. There was a sign in the waiting area informing patients that they could request to be seen in private instead of at the reception window. The practice were aware of this and had consulted with the landlords of the property to make improvements, additional holes were added to the security screen at the desk to ensure patients could hear the receptionist.

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 rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and who completed comment cards told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

From the 2014 National GP Patient Survey we saw scores in involving patients in their care and treatment were above the national average, 90.2% of patients said the GP they visited had been 'good' at involving them in decisions about their care (national average was 81.8%). The data showed that 85.2% of patients said the practice nurse they visited had been 'good' at involving them in decisions about their care (national average 85.1%).

We asked staff how they made sure that people who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service, either in person or by telephone.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information on support groups and a range of information regarding common health conditions.

There was a palliative care register and regular contact with the district nurses. There were monthly palliative care meetings which involved GPs and MacMillan nurses.

Staff told us that if families had suffered bereavement, this was followed up by the practice, with either a visit or telephone call depending upon the circumstances.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients who were aged over 75 had a named GP. The daily on-call GP gave priority for follow up for the elderly and high risk patients.

The practice had a palliative care register and had monthly multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure communication of changes in care and treatment.

Patients who were carers were identified on their medical records so that the practice could identify them to be aware of their support needs.

The practice had care plans in place for patients with learning disabilities and for those experiencing poor mental health. The practice said staff knew these patients and their carers well and arrangements were often made to review them in the community, the practice recognised that this group of patients had poor attendance rates for reviews.

The practice had recently consulted the patient participation group (PPG) regarding the questions which were to be asked of patients in the next survey of patients which was to be carried out; the questions were in draft and to be discussed at a future PPG meeting.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to telephone translation services if required, for those patients whose first language was not English.

The premises had been designed to meet the needs of people with disabilities. Treatment and consulting rooms could be accessed by those with mobility difficulties, the front doors to the surgery opened automatically. The patient toilets could be accessed by patients with disabilities and there were designated disabled parking spaces in the surgery car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties and there was large print literature available.

Access to the service

Patients were frequently and consistently not able to access appointments in a timely way. All of the seven patients we spoke with raised concerns about the appointment system. Eight of the 24 CQC comment cards also raised similar concerns with the appointment system. Patients said they felt the appointments system was unsatisfactory, they told us there was a rush at 8:15am on a morning for patients via the telephone and queuing in person at reception to secure appointments. Words used to describe the appointment system included unrealistic, poor and difficult. Patients we spoke with and staff confirmed there was a queue of patients outside the practice every morning to ensure they could obtain an appointment.

The latest GP Patient Survey completed in 2013/14 showed that patient satisfaction was below the national averages for access. The percentage of patients satisfied with phone access was 62.1%, the national average was 75.4% and the satisfaction for opening hours was 77.7%, the national average was 79.9%.

The practice carried out its own patient survey in June and July 2013. 51% of patients found it fairly easy to make an appointment, 30% not very easy and 11% very easy. Most of the comments referred to patients being unable to book an appointment easily, particularly from working patients. No formal action plan was formulated to address these issues following the survey.

The practice was open Monday to Friday from 8:00am until 6:30pm and closed on Wednesday lunchtime from 1:00pm until 2:00pm. Appointments were released at 8:15am every day. Routine appointments could not be booked easily. To book these the patient had to contact the practice either two or seven days before they needed the appointment, when they were released at 8:15am on that day. Appointments could be booked via telephone, at reception or on-line. Staff confirmed this led to a queue every morning and gave the working patient population a problem with having to contact the surgery at a set time in order to obtain a routine appointment.

Half of the appointments on any day were pre-bookable on the same morning and half set aside for urgent appointments. Urgent, on the day appointments slots were filled quickly and staff told us the duty doctor would decide

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

if patients were seen once there were no appointments available or alternatives would be offered such as the local walk in centre. The practice had all female GPs and had no access to a male GP if the patient requested this.

Whilst in the reception area we saw an elderly couple who asked for an appointment, they were turned away by the receptionist and asked to come back the next day. A patient we spoke with told us they had witnessed patients upset in the waiting room because they could not have an appointment and being told to come back the next day.

Staff told us they felt the appointment system left them frustrated and left patients angry and upset and they had to deal with the fall out of this. They had received training for dealing with challenging patients. Staff told us that the practice had tried various appointment systems to try and improve access for patients. For example a GP led triage system had previously been in place, however this was no longer used as patients knew to say their need for an appointment was urgent and GPs ended up seeing routine appointments as an urgent consultation so the patient could obtain an appointment.

The patient information leaflet stated there were early morning working patient appointments available at 7:30am every week. We asked staff about this. We were told this used to be a Wednesday morning and was then changed to a Thursday, however due to staff shortages there had been no early morning appointments available for the last three to four weeks.

We asked the GP partners and business manager about access to appointments. They told us they had worked with a transformation team from the clinical commissioning group (CCG) regarding patient demand. They had been disappointed with the results of this as it had not really offered any solutions to the issues they faced and they were hoping it would have assisted them to improve access for patients. They were currently recruiting more clinical staff and the pharmacist attached to the practice was running a minor ailments clinic one half day a week. The numbers of appointments available to be booked on line had been increased. We were told that the practice had trialled other types of clinics such as training staff to run walk in phlebotomy clinics to take pressure from the appointments system.

Listening and learning from concerns and complaints

The practice was not following recognised guidance and contractual obligations for GPs in England. The practice complaints policy was undated and did not have a review date. The policy referred to the Primary Care Trust which was abolished in 2013 and stated that the complaints manager for the practice was the practice manager; the practice had not had a practice manager for a few years.

The practice provided us with minutes of the last complaints meeting they had held which was in February 2015. There were 34 documented complaints between May and December 2014, 23 of the complaints referred to problems patients had regarding the appointment system. The most common theme was that patients were frustrated at not being able to book appointments in advance. Patients also complained at not being able to get through to the surgery on the telephone and not being able to obtain a routine appointment for two weeks or more. The meeting concluded that the complaints had been resolved in a satisfactory manner, that the GPs acknowledged there was an on going issue with the lack of appointments and an access problem and they would continue to take steps towards reaching a solution. However, this had not had a positive impact on the patient's ability to access appointments.

We looked at the complaints file, there had been 41 complaints overall in 2014 and eight in 2015. However, staff told us that not all verbal complaints were documented as there was not enough time to do this. Complaints had been acknowledged and answered by the practice.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a vision or strategy for the future. There was no business development plan or business development meetings. There was a lack of evidence of long term strategic review and the practice were working day to day with no planning ahead in place.

The practice recognised areas in which they needed to improve and told us that these were patient access, repeat dispensing and improving the use of their IT systems. The practice were actively trying to recruit new GPs into the practice.

Governance arrangements

There was a lack of effective governance arrangements. There were policies and procedures in place; however these were not up to date. Not all of the staff we spoke with knew how to access these. They were aware there was a business continuity plan but did not know where it was kept or what it included. There were risks to the health and safety of patients and staff which had not been assessed. We saw a limited system of clinical audit.

There was a leadership structure with named members of staff in lead roles. For example, there were lead GPs for finance and safeguarding. However, for some of the staff in lead roles, such as infection control, staff were not appropriately trained. The practice management function was not fully exercised or well developed.

Leadership, openness and transparency

The practice held staff meetings. Partners meetings were held every week on a Monday, we saw minutes of these. There was an informal meeting for administration staff on a Wednesday lunchtime when the practice was closed. We were told there were clinical meetings which included the practice nurses every month. However, there were no minutes of either of these meetings made available to us.

Staff did not learn from each other. Staff we spoke with said they did have meetings but some staff said they felt they could be better informed of what was happening in the practice, they did not get much feedback from the GP partner's meetings. Most staff told us they felt supported and had received training, however, there were no robust systems in place in terms of monitoring training.

Practice seeks and acts on feedback from its patients, the public and staff

Staff did not feel engaged in the planning and delivery of services, told us they felt the main reason for the problems with the appointment system was that patients could not book appointments in advance. They told us the GP partners decided how the appointment system was run and they were not asked for feedback on how this could be improved.

The practice had a patient participation group (PPG) which met quarterly and had three members. There was also a virtual group of patients who the business manager could contact via email to gain views. We spoke to a member of the PPG who told us the group was still relatively new but worthwhile and the practice had been consulting them on the questions they were going to ask in a forthcoming patient survey. The practice had produced a document "What you said, What we did" as a result of consultation with the PPG. The PPG raised the issue of a limited number of appointments available; in response the practice offered a minor ailments clinic to take pressure from the appointments system.

We asked the business manager when the last patient survey was held. On the day of the inspection we were told this was in 2011. Following the inspection we were sent data from a survey which was carried out by the practice in June and July 2013. It was unclear how many overall responses came from this survey and there was no action plan to address issues raised in the survey.

Management lead through learning and improvement

There was little innovation or service development. The managers at the practice had tried to improve the access to appointments for patients, however, there had been no improvement and patients were still unable to obtain appointments when they needed them.

There was some evidence of learning and reflective practice. Some staff did feel supported by their managers and could go to them if they needed support. However, evidence of training could not be provided and some compulsory training had not been carried out.

Staff did not receive any feedback on the significant events process or receive any learning as a result of the incidents they reported.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff did not receive appropriate training in order to carry out the duties they perform. The provider could not demonstrate that Healthcare professionals continued to meet professional standards which are a condition of their ability to practice or a requirement of their role. It appears to the Commission that the above cited conduct is continuing failure to remedy breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of Regulation 18 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing (2) (a) (c)

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not effectively assessed or done what was reasonably practical to mitigate the risks to the health and safety of patients receiving care and treatment in relation to patients being able to obtain a consultation with a healthcare professional. It appears to the Commission that the above cited conduct is continuing failure to remedy breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Self care and treatment. (2) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not established and operated effectively in order to assess, monitor and improve the quality of service provided in carrying out the regulated activities. Risks were not effectively assessed, monitored and mitigated in relation to the health, safety and welfare of patients and staff. Records which were necessary to be kept in relation to person's employed in carrying out the regulated activity and in relation to the management of the regulated activity were not maintained. Evaluation of information to improve practice had not been carried out effectively.

This section is primarily information for the provider

Enforcement actions

It appears to the Commission that the above cited conduct is continuing failure to remedy breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. (1), (2) (a) (b) (d) (f)