The Haymarket Health 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.

Contents

Summary of this inspection

Page

Overall summary 1

Areas for improvement 3

Detailed findings from this inspection

Our inspection team 4

Background to The Haymarket Health Centre 4

Why we carried out this inspection 4

How we carried out this inspection 4

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of The Haymarket Health Centre on 11 January 2017. Breaches of legal requirements were found and a warning notice was served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. A Requirement notice was served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. We rated the service overall as inadequate and placed the service into special measures to give people who use the service the reassurance that the care they get should improve. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for The Haymarket Health Centre on our website at www.cqc.org.uk.

We undertook a focused follow up inspection on 3 July 2017 to check that the practice had taken urgent action to

Summary of findings

ensure they met the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. This report only covers our findings in relation to the warning notice. A follow up inspection will be carried out to check that the practice has followed their action plan for the requirement notice and to confirm they have met legal requirements.

Our key findings were as follows:

- The practice had responded positively to the warning notice and had addressed issues previously identified in the warning notice.
- The practice had completed 13 clinical audits to include two full cycle audits since our last inspection which demonstrated improved outcomes to patients.
- The culture of reporting significant events had improved across the practice. A template for recording significant events had been developed and incidents had been recorded, investigated and shared. Staff were encouraged and were aware of how to raise a significant event.
- A protocol had been developed and implemented for the management of laboratory results such as bloods and urine.
- Additional clinical staff had been appointed to meet patient demand for access to appointments. The practice were encouraging patients to book on line and had recently opened a new patient access line managed by a dedicated patient contact call centre. This was to improve patient access and ensure patients were appropriately signposted to the appropriate clinician. However, some patients told us they were still experiencing difficulty getting through to the practice by telephone and obtaining appointments, particularly on a Saturday.
- Systems and processes to safeguard patients had improved. Staff were aware of how to raise a safeguarding concern, had received training and had access to internal leads. The practice were re-establishing links with external agencies such as the health visitor and meetings had been held.
- All staff had received chaperone training and were aware of the correct procedure to follow if they were required to chaperone. A chaperone policy and template had been developed and was accessible to staff to record patient requests for a chaperone.
- Clinical leadership and structure had been developed and implemented. Key roles and responsibilities had been developed across the team. Staff felt supported by the management team, were aware of the leadership structure and considered communication had improved. Staff had received an appraisal of their work.
- The partners demonstrated oversight and understanding of the practice. They were aware of the continued improvements required to improve patient outcomes, staff culture and the quality of the service.
- Governance arrangements had improved with the implementation of clinical meetings, improved communication, an increase in staffing in addition to a new management team and change of clinical system.
- There was a formal system in place to log, review, discuss and act on external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety.
- The provider had reviewed the arrangements for medicines carried in GP bags for home visits. A risk assessment had been completed and a decision made not to carry any emergency medicines on GP home visits. However, the risk assessment did not consider all eventualities of how risk was mitigated for each individual condition.

However, there is an area of practice where the provider needs to make improvements.

The provider should:

- Review the method of communication used for advising patients to have a follow up blood test in relation to the results.

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

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Review the method of communication used for advising patients to have a follow up blood test in relation to the results.

The Haymarket Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP Specialist Advisor.

Background to The Haymarket Health Centre

The Haymarket Health Centre is registered with the Care Quality Commission (CQC) as a partnership provider. The practice holds a General Medical Services (GMS) contract with NHS England and is part of the NHS Stoke On Trent Clinical Commissioning Group (CCG). A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice is located in Tunstall, Stoke-On-Trent. The area of Tunstall is measured as having one of the highest levels of deprivation in the country. The practice age distribution is in line with the national and CCG area. The practice has a higher percentage of patients with a long-standing health condition which could mean increased demand for GP services. At the time of the inspection the practice had 11,458 registered patients. The practice had previously experienced premises and significant recruitment issues and a request for support was made by the practice from NHS England The 'Supporting Change in General Practice' team. This resulted in a change of governance and new leadership from 3 October 2016. The practice is now operated by the GPs of a practice which is situated approximately four miles away. The aim of the collaboration is to facilitate cross site working. Shared policies and procedures have been implemented enabling staff to access information technology and training facilities at both sites. A new patient access line, managed by a dedicated patient contact call centre, has recently been implemented to improve patient access and ensure patients are signposted to the appropriate clinician. The practice have updated their registration details with the CQC following the changes in staff.

The practice staffing comprises of:

- Five GPs - to include one GP managing partner, two salaried GPs and two GPs who are partners of the organisations other local GP practice. (Three male and two female) 4.5 whole time equivalent (WTE)
- One business partner
- Three nurse practitioners and one advanced nurse practitioner 3.75 WTE
- One lead nurse Quality and Compliance/ independent prescribing nurse practitioner 1 WTE
- One prescribing pharmacist
- Two practice health care workers - 1.8 WTE
- One Primary Care Operations Manager
- One Patient Communications Manager
- One Systems Development Manager
- A team of ten reception and administrative staff including a reception manager
- A team of call handlers (based off site)

The practice is open between 8am and 6pm Monday to Friday with extended hours appointments offered on Saturday mornings from 8.15am to 12.30pm. The practice offer a mixture of same day and pre-bookable appointments up to eight weeks in advance in addition to telephone consultations.

The practice has opted out of providing cover to patients in the out-of-hours period. During this time services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

Detailed findings

Why we carried out this inspection

We undertook a focused inspection of The Haymarket Health Centre on 3 July 2017 under Section 60 of the Health and Social Care Act 2008 to follow up on our previous comprehensive inspection on 11 January 2017. At the comprehensive inspection we identified breaches of legal requirements were found. A warning notice was served for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance and a requirement notice for Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The full comprehensive report following the inspection on 11 January 2017 can be found by selecting the 'all reports' link for The Haymarket Health Centre on our website at www.cqc.org.uk.

This focused inspection was undertaken to ensure that the provider had met the requirements and timescales of the warning notice issued to them against Regulation 17 of the Health and Social Care Act 2008. This report only covers our findings in relation to the warning notice.

How we carried out this inspection

We carried out a focused follow up inspection of The Haymarket Health Centre on 3 July 2017.

During our visit we:

- Spoke with a range of staff to include two GPs, the business partner, patient communications manager, advanced nurse practitioner, elderly care assessor, reception manager, four receptions, an administrator and the systems development manager.
- Spoke with 11 patients using the service.
- Observed how patients were being cared for in the reception area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans and other information the practice provided during the inspection.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services well-led?

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

Our findings

At our previous inspection on 11 January 2017, we found that care and treatment was not being provided in a safe way to patients. This was because:

- Care and treatment was not always monitored regularly. Clinical audits were not routinely carried out to improve care, treatment and people's outcomes.
- There were few reports of serious incidents or significant events and there were no significant event management protocols and limited evidence to show that significant events were reviewed and thoroughly investigated to prevent further occurrences. Some staff were unaware of the procedure for recording significant events.
- There was no blood test results management protocol. This meant that clear guidance was not available for staff, including locums to manage the pathology results therefore posing a risk to patient safety.
- There was insufficient access to appointments. Patient surveys indicated that only 50% of patients could get through to the practice to make an appointment by telephone and only 64% could get an appointment when they needed one. Some patients told us they were unable to get an appointment for an urgent need.
- The provider did not have systems and processes in place to ensure that sufficient numbers of staff were deployed to meet the needs of patients.
- Systems and processes were not established and operated effectively to prevent abuse of people using the service. No safeguarding meetings were held and the practice were not working in partnership with other relevant bodies to contribute to developing plans for safeguarding children and adults at risk, including regularly reviewing outcomes for people using the service.
- Staff did not always adopt the correct procedure when chaperoning.
- Clinical leadership was not effective, staff division was seen, staff were unsure of the way ahead. Some staff said that they felt unsure as to the leadership structure and that more vision and clearer communication were needed. Some staff stated that they felt unsettled and that they did not know where the practice was going. Several members of key staff had left.
- There was evidence to show there was a failure of the partners and practice manager to demonstrate oversight and understanding in respect of the practice. The approach to service delivery and improvement had been reactive and focused on short term issues. Improvements had not always been identified or action not always taken. Where changes had been made, the impact on the quality of care had not been fully understood or monitored, for example with the shortage of clinical staff.
- The provider did not ensure that effective governance arrangements were in place. Clinical meetings had not been held since April 2016. Staff had not had an appraisal in the past year.
- There was no procedure in place to ensure that Medicines and Healthcare products Regulatory Agency (MHRA) medicine safety updates and near misses were carried out. We found that searches had not been conducted following MHRA medicine safety updates, this meant that patients were at a high risk of avoidable harm.
- There was evidence to show that the procedures for managing medicines in the practice did not always ensure patients were safe. The registered person did not have any procedures in place for checking medicines in the GP's bag and out of date medicines were found in one of the GP's bag.

Vision and Strategy

At our inspection in January 2017 we saw the practice had been under new leadership from October 2016. The practice had previously experienced premises and significant recruitment issues. This resulted in a change of governance and new leadership from 3 October 2016. The practice is now operated by the GPs of a practice which is situated approximately four miles away. The aim of the collaboration was to facilitate cross site working, and a number of shared policies and procedures have been implemented enabling staff to access information technology, training facilities and patient contact centre at both sites.

- The practice had a mission statement and staff spoken with were aware of the aims and values of the practice which was to offer the best care possible to patients within the current health economy, improve care and efficiency and have a supportive relationship amongst employees and staff and give the staff opportunity to develop their skills to perform their role to the best they can. We saw the mission statement was clearly displayed throughout the practice including the reception area and on the practice website.

Are services well-led?

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

- At the previous inspection we saw the practice had a strategy and supporting business plans which reflected the vision and values, but these were new and not embedded in to practice. During this inspection we saw a leadership and management structure and key roles and responsibilities had been developed and implemented. Staff we spoke with were complimentary of the management and leadership arrangements in place and were aware of the vision for the future.

Governance arrangements

We saw an improvement in governance arrangements with the implementation of clinical meetings, improved communication, an increase in staffing in addition to a new management team and change of clinical system. The provider told us in their action plan that they were committed to a cultural change within the practice as part of a larger organisation and acknowledged that they still needed to make continued improvements going forward. They told us they had instilled positive staff morale and teamwork and staff were embracing change and motivated in their work which was confirmed by the staff we spoke with. Staff told us they knew the direction the practice was going in and were happier and felt more supported in their work.

At our last inspection we identified that few first cycle audits had been completed. At this inspection we found the practice had completed 13 audits to include two full cycle audits which demonstrated improved outcomes to patients and a commitment to the practices ongoing quality assurance and quality improvement programme. For example, we identified at the previous inspection that the practice had not acted on an external medicine alert for spironolactone and renin-angiotensin system medicine in heart failure, which posed a risk of potentially fatal hyperkalaemia (high blood potassium levels). At this inspection we saw the practice had carried out a two cycle audit for patients prescribed this medicine and the frequency of blood monitoring was checked and actioned. Reminder letters were sent to patients along with a blood form. Following the second audit all but one patient had attended and a letter was sent to the remaining patient advising they attend within a set timescale otherwise it was unsafe for the practice to continue to prescribe their medicine. The practice had recently changed their clinical systems and audits had been set up to run searches automatically to identify those patients requiring review or monitoring.

The culture of reporting significant events had improved across the practice. There was a designated member of the management team responsible to overseeing significant events. A single reporting template for recording significant events had been developed, shared across the organisation and was available on the shared drive for staff to access. We saw 22 significant events had been raised since our last inspection and these had been recorded, investigated and shared. Staff spoken with were aware of how to raise a significant event and told us they were encouraged to raise and record events and these were investigated by the designated member of the management team. We saw significant events were a standing agenda item and discussed and minuted at monthly clinical meetings. A member of staff shared a recent example of a significant event regarding a patient with the same name. We saw this had been recorded, shared, investigated and actioned but the practice had not taken the learning forward by looking for other patients with similar names. During the inspection dates were scheduled to carry out a regular analysis of significant events to identify any patterns or common trends and maximise learning.

Since the last inspection a protocol for the management of laboratory results had been developed and implemented. The protocol clearly detailed the responsibilities for both patients and the practice. Incoming pathology results were sent electronically to the clinician who had requested the test. A single clinical system had very recently been adopted across the organisation to allow for a more effective and uniform processing and a clear way of viewing and processing of clinical results if a clinician was away for periods of 48 hours or longer. There was a procedure in place for both normal and abnormal results. However, we found there was not a consistent or effective approach to the actions taken. For example, two GPs contacted patients to inform them to have a follow up blood test via text messaging them, which potentially is not a reliable method of communication.

The practice were addressing issues relating to access to appointments. The provider told us they were committed to resolving and managing the high patient demand and were in the process of re-educating patients that not all patients needed to be seen by a GP but could be seen by other clinicians within the practice. The provider had very recently opened a new patient access line managed by a dedicated patient contact call centre to improve patient

Are services well-led?

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access and ensure patients were signposted to the appropriate clinician. Additional appointments had been created due to an increase in clinicians. We saw the practice were encouraging patients to book on line and patients were being supported by a member of staff to use the self-check in and register for online services. Patient contact details were also being checked to ensure the practice had up to date contact details.

We saw patients were able to book appointments in person, on line, or telephone eight weeks in advance. Same day appointments were released at 8am for patients with urgent medical needs. Each GP offered four telephone consultations per day and the practice were looking to increase this to six consultations. Ten urgent on the day GP appointments were available and 18 urgent nurse practitioner appointments in addition to pre-booked appointments. Nurse practitioners offered six telephone consultations per day. A practice pharmacist had also recently joined the team and was in the process of being trained up to see patients. All staff were able to access the appointment system which detailed the availability of each clinician. The nurse appointment system detailed what condition each nurse had the clinical expertise to manage so staff knew the appropriate clinician to book patients in with. Staff we spoke with told us appointment availability had improved due to the increase in clinicians working at the practice. Records showed the next pre-bookable appointment was 10 July 2017. Some of the patients we spoke with told us they continued to have difficulty getting through to the practice by telephone despite the new central patient contact call centre recently being introduced and therefore was reliant on visiting in person to make an appointment. Shortly following the inspection we received a complaint from a patient in relation to telephone access and referred this to the provider. They carried out an evaluation of the data since changing to the new system and shared this with us. Following this review the provider told us they would be adding an additional full-time member to the call team from 1 August 2017 and for as many hours possible prior to this date. In addition they would re-configure the distribution of incoming calls to the call handlers to give an additional dedicated call handler to The Haymarket Health Centre telephone number. The provider also told us they were looking at bringing forward their proposed start date for offering cross site appointment access for same day appointments with their other local practice due to having unused appointments available on a number of days.

Additional clinical staff had been appointed to meet patient demand for access to appointments. The provider told us since the last inspection a number of new staff had been appointed to include three GPs, an advanced nurse practitioner, two nurse practitioners, three practice nurses and a practice pharmacist. An additional advanced nurse practitioner was due to join the team in September 2017. We were told these staff were based at practice and also worked at the other practice some four miles away.

Systems and processes to safeguard patients had improved. The provider was in the process of validating registers of vulnerable patients as they had identified some coding issues in the practice's computer system. We saw the practice had acted in relation to a request for information from an external agency in relation to a 'child in need' and had raised a significant event as a result of their findings and had discussed the case at a clinical meeting. An alert had been placed on the system to alert staff that the patient had a 'child in need' plan in place but had not identified the parent or the child's siblings as per their policy. This was immediately actioned during the inspection. Staff we spoke with were aware of how to raise a safeguarding concern and who the designated internal safeguarding leads were. We saw the practice were re-establishing links with external agencies such as the health visitor and meetings had been held and minuted. However, we noted that there was no GP representation at these meetings. Safeguarding reports were completed as requested and forwarded to external agencies and staff had received safeguarding training.

Since the last inspection all staff had received chaperone training and had a training pack. Staff spoken with were aware of the correct procedure to follow if they were required to chaperone. A chaperone policy and template had been developed and was accessible to staff to record patient requests for a chaperone. Posters were displayed in the reception area and in consultation and treatment rooms advising patients that chaperones were available. Patients we spoke with were aware they could request a chaperone and one patient told us they had been offered and used this service on the day of the inspection.

Are services well-led?

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

Since the previous inspection a structure for clinical leadership had been developed and implemented. An organisation chart was in place and key roles and responsibilities had been developed across the team. All of the staff we spoke with told us they felt supported by the management team, were aware of the leadership structure and considered communication had improved. Staff had also received an appraisal of their work. A programme of clinical and administrative meetings was in place and copies of meeting minutes were shared with us. We saw meetings provided an opportunity to discuss and share best practice. Staff were provided with protected learning time to complete essential training. A whole practice meeting had yet to take place due to the challenges of getting all of the staff to attend.

The management team demonstrated oversight and understanding of the practice. They told us it was the whole team's determination and desire to provide the patients at the practice with a high quality and effective service. They were aware of the continued improvements required to improve patient outcomes, staff culture and the quality of the service.

The practice's process for acting on external medicines alerts had improved. We saw a formal system had been introduced to log, review, discuss and act on alerts such as alerts sent by the Medicines and Healthcare products Regulatory Agency (MHRA). We looked at what action the practice had taken in relation to recent medicines alerts issued that may affect patient safety. The provider was able to demonstrate that they had taken the appropriate action on these alerts and we saw this was discussed as part of clinical meetings held and minuted.

The provider had reviewed the arrangements for medicines carried in GP bags for home visits. A risk assessment had been completed and a decision made not to carry any emergency medicines on GP home visits. However, the risk assessment did not consider all eventualities of how risk was mitigated for each individual condition. GPs told us if a patient required emergency medicines during a home visit they would call an ambulance and always risk assessed the situation before visiting a patient at home.