SSAFA Care CIC Health and Walk In Centre

Quality Report

The Merlyn Vaz Health & Social Care Centre
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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?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at SSAFA Care CIC Health and Walk In Centre on 21 March 2017. Overall the practice is rated as inadequate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, reviews and investigations were not thorough enough. Not all members of staff were involved in regular significant event meetings.
- Patients were at risk of harm because systems and processes to keep them safe were ineffective. For example, the processes in place to review and monitor patients prescribed high-risk medicines was inconsistent and reviews were not always completed in accordance with best practice guidance.
- Patient care records in relation to some home visits carried out were not found to be accurate and did not represent the actual care and treatment of patients. Clinical staff were unable to confirm whether some visits had taken place.
- Although some clinical audits had been carried out, not all audits were used to drive improvements to patient outcomes.
- There was a system in place within Leicester, Leicestershire and Rutland CCGs for all urgent care services including some emergency services whereby these providers had access to twice daily calls to discuss and monitor patient demand and capacity. These providers worked together in cases of high demand on services and put emergency plans into place to ensure effective use of these services within LLR.
- There was one key performance indicator in place between the local CCG and the walk in centre which was to ensure 90% of patients to be seen within 30 minutes of arrival. The practice continually achieved this KPI throughout the past 12 months, we saw

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evidence to show that the achievement for January-March 2017 was 97% compared to October-December 2016 when the practice achieved 98%.

- Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses.
- Information about services and how to complain was available and easy to understand. However, the practice did not have a system in place for all staff including non-clinical staff to learn from complaints through discussion at regular meetings or via direct feedback.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a number of policies and procedures in place to govern activity.

The areas where the provider must make improvements are:

- Review governance and clinical oversight arrangements including systems for assessing and monitoring risks and the quality of the service provision such as implementing a system of effective clinical audits and re-audits to improve patient outcomes.
- Review process in place to ensure the safeguarding register is up to date and accurate and monitored regularly.
- Ensure systems and processes are in place to ensure patients prescribed high-risk medicines are monitored appropriately ensuring all required reviews are carried out.
- Ensure that an accurate, complete and contemporaneous record is maintained for every patient.
- Review processes for reporting, recording, acting on and monitoring significant events, incidents, near misses and complaints. Ensuring actions taken and lessons learned are shared with the wider team and actions are documented with timely review dates.

In addition the provider should:

- Review methods of communication and meeting structures to ensure all practice staff clinical and non-clinical are provided with the opportunity to be involved in discussions about the practice.

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 providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- Patients were at risk of harm because not all appropriate systems and processes were implemented in a way to keep them safe. For example, the processes in place to review and monitor patients prescribed high-risk medicines was inconsistent.
- There was insufficient attention to safeguarding children and vulnerable adults. For example, the vulnerable adults and children register was out of date and required review.
- Patient care records in relation to some home visits carried out were not found to be accurate and did not represent the actual care and treatment of patients. Clinical staff were unable to confirm whether some visits had taken place.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Although some clinical audits had been carried out, not all audits were being used to drive improvements to patient outcomes. For example, those in relation to patients prescribed high risk medicines.
- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

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- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 48 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available. However, some complaints we looked at may have constituted a significant event analysis and we did not see evidence that this had taken place. The practice did not have a system in place for all staff including non-clinical staff to learn from complaints through discussion at regular meetings or via direct feedback.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a vision to deliver quality care and focus on patient needs and education.
- The practice did not have an effective governance framework in place. There was a lack of effective systems and processes in place and clinical oversight. For example, there was a lack of

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clinical oversight in place to ensure the safe monitoring of patients prescribed high risk medicines. Patient care records were not always reflective of the actual care and treatment of patients.

- Although some clinical audits had been carried out, we saw no evidence that audits were monitoring quality or improvements to patient outcomes.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- Not all members of staff were involved in regular significant event meetings.

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 was rated as inadequate for being safe, effective and for being well-led and good for being caring and responsive. The issues identified as being inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of older people.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.

People with long term conditions

Inadequate

The practice was rated as inadequate for being safe, effective and for being well-led and good for being caring and responsive. The issues identified as being inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of people with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was 76% which was lower than the CCG average of 86% and the national average of 90%. (exception reporting rate was 14% which was higher than the CCG average of 8% and the national average of 12%).
- The lead GP had a specialist interest in the diabetes management and held a regular dedicated diabetes clinic for patients including pre-diabetic patients.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

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- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care.

Families, children and young people

Inadequate

The practice was rated as requires improvement for being safe, effective and for being well-led and good for being caring and responsive. The issues identified as being inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to five year olds ranged from 82% to 94%.

  Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

Inadequate

The practice was rated as inadequate for being safe, effective and for being well-led and good for being caring and responsive. The issues identified as being inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these

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were accessible, flexible and offered continuity of care. For example, we were told that patients who were registered with the practice could be seen in the walk in service if they presented at the practice and requested an on the day routine or urgent appointment.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The practice was rated as inadequate for being safe, effective and for being well-led and good for being caring and responsive. The issues identified as being inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice was rated as inadequate for being safe, effective and for being well-led and good for being caring and responsive. The issues identified as being inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

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- The practice carried out advance care planning for patients living with dementia.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- Performance for mental health related indicators was 100% which was the maximum amount of points available compared to the CCG average of 93% and the national average of 93%. (exception reporting rate was 12% which was similar to the CCG average of 11% and the national average of 11%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing higher than local and national averages. 364 survey forms were distributed and 96 were returned. This represented 2% of the practice's patient list.

- 85% of patients described the overall experience of this GP practice as good compared with the CCG average of 80% and the national average of 85%.
- 81% of patients described their experience of making an appointment as good compared with the CCG average of 68% and the national average of 73%.
- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 69% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 51 comment cards which were all positive about the standard of care received. Patients told us that staff were kind, helpful and caring.

Friends and Family test results showed that 100% of patients who had responded said they would recommend this practice to their friends and family.

Areas for improvement

Action the service MUST take to improve

- Review governance and clinical oversight arrangements including systems for assessing and monitoring risks and the quality of the service provision such as implementing a system of effective clinical audits and re-audits to improve patient outcomes.
- Review process in place to ensure the safeguarding register is up to date and accurate and monitored regularly.
- Ensure systems and processes are in place to ensure patients prescribed high-risk medicines are monitored appropriately ensuring all required reviews are carried out.
- Ensure that an accurate, complete and contemporaneous record is maintained for every patient.
- Review processes for reporting, recording, acting on and monitoring significant events, incidents, near misses and complaints. Ensuring actions taken and lessons learned are shared with the wider team and actions are documented with timely review dates.

Action the service SHOULD take to improve

- Review methods of communication and meeting structures to ensure all practice staff clinical and non-clinical are provided with the opportunity to be involved in discussions about the practice.

SSAFA Care CIC Health and Walk In Centre

Detailed findings

Our inspection team

Our inspection team was led by:

This inspection was led by a CQC lead inspector**.** The team included a second CQC inspector a GP specialist advisor and a practice nurse specialist advisor.

Background to SSAFA Care CIC Health and Walk In Centre

SSAFA Care CIC Health and Walk In Centre is located in the city centre of Leicester within the Merlyn Vaz Health and Social Care Centre which is purpose built and is shared with three other GP practices, a pharmacy and other local health services such as midwifery and mental health services. The health centre has staff and patient car parking available including disabled parking spaces.

The GP practice provides primary medical services to approximately 4,926 registered patients. SSAFA are an armed forces charity and provide lifelong support to armed forces personnel and their families. SSAFA Care Community Interest Company (CIC) (the provider) formed in 2008 to deliver NHS healthcare and began providing primary medical services in Leicester in January 2009. The walk in centre began providing services in 2009, initially on a five year contract and is commissioned to provide a GP led minor illness and minor injury service. The integrated registered GP practice and walk in service contract is currently part of a procurement process. The new contract will be a continuation of this service and will include an additional GP practice.

It is located within the area covered by NHS Leicester City Clinical Commissioning Group (LCCCG). It is registered with the Care Quality Commission to provide the regulated activities of; the treatment of disease, disorder and injury; diagnostic and screening procedures; family planning; maternity and midwifery services and surgical procedures.

The practice has a higher than average distribution of registered patients between the ages of 25-44 years of age and a significantly lower distribution of patients aged over 44 years of age compared to local and national averages. 38% of the patient population have a long standing health condition compared to the local average of 50% and the national average of 53%.

At the time of our inspection the practice employed one lead GP (male) and three locum GPs (two male, one female) who provide locum services on long-term basis. All other nursing staff including three advanced nurse practitioners, one nurse practitioner and two practice nurses are locum staff, most of whom work at the practice regularly. The practice employed a team of seven reception and administration staff and two health care assistants on a permanent basis. The clinical team and non-clinical staff are supported by a group practice manager.

The GP practice is open from 8am until 6.30pm, Monday to Friday. The walk in centre is open from 8am until 8pm seven days per week for anyone entitled to NHS services, whether registered with the practice, another GP practice or not NHS registered at all. They also provide services to overseas visitors. During April 2015 to April 2016, the walk in centre saw 19,600. During a six month period from September 2016 to February 2017, the walk in centre saw 12,233 patients.

Detailed findings

The practice provides on-line services for patients such as to book routine appointments and ordering repeat prescriptions.

The practice has an Alternative Provider Medical Services contract (APMS). An APMS contract is provided under directions of the Secretary of State for Health and can be used to commission primary medical services from GP practices as well as other types of service providers.

The practice has opted out of providing the out-of-hours service. This service is provided by the out-of-hours service accessed via the NHS 111 service. Advice on how to access this service is clearly displayed on the practice website, in the practice leaflet and over the telephone when the practice and walk in centre is closed.

Why we carried out this inspection

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. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as NHS Leicester City Clinical Commissioning Group (LCCCG) and NHS England (NHSE) to share what they knew. We carried out an announced visit on 21 March 2017.

During our visit we:

- Spoke with a range of staff which included a lead GP, group practice manager, locum advanced nurse practitioner, locum practice nurse, salaried health care assistant and two members of the reception team and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed 51 comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording incidents and significant events however it required review. For example:

- Staff told us they would inform the lead GP of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. There had been 13 significant events reported since June 2015 however, we noted that the practice did not always carry out a thorough investigation or analysis of the significant events reported. For example, we saw evidence of patient case discussions and other incidents discussed in meeting minutes, however some of these discussions had not had a significant event analysis carried out and there was a lack of evidence of actions taken as a result or learning lessons shared with the wider team. Non-clinical staff were not always aware of or involved in meetings or discussions in relation to significant events. Documentation of records of some significant events we looked at did not always include full details of investigations carried out or outcomes. Following our inspection, the practice submitted an action place to the Commission which included evidence of a revised incident reporting policy.
- Clinical staff told us they received alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). We were informed that alerts were co-ordinated and disseminated to clinicians by the practice manager and were discussed during weekly clinical meetings. Staff we spoke with were able to tell us about recent alerts received and we saw documented evidence of recent alerts disseminated to staff which included records of actions taken as a result.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety however, some of these systems and processes required review. For example:

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The lead GP was the lead member of staff for safeguarding. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- The practice had a discreet and effective system in place to alert clinical staff via the electronic patient care record of any patients who were either vulnerable, had safeguarding concerns or suffered with a learning disability. The practice had a register of vulnerable adults and children in place however, the practice nor the safeguarding lead did not actively review this register. We noted that this register was not up to date during our inspection. For example, the register contained details of patients who were no longer required to remain on this register.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3. Practice nurses were trained to level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- A member of the practice nursing team was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep

up to date with best practice. There was an IPC protocol and staff had received up to date training. During our inspection, we saw that IPC audits were undertaken on a four monthly basis and we saw evidence that action was taken to address any improvements identified as a result.

Some of the arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Processes were in place for handling repeat prescriptions, however the processes in place to review patients prescribed high-risk medicines was inconsistent. During our inspection, we noted that some patients had not received the appropriate monitoring before a prescription was re-issued. This included medication such as Azathioprine, ACE Inhibitors and Thyroxine and posed a serious risk to the patients' safety, health and welfare.
- Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice did not carry out regular medicines audits and we observed that prescribing was not always carried out in line with best practice guidelines for safe prescribing in relation to patients prescribed high risk medicines. Following our inspection, the practice submitted an action place to the Commission in relation to these concerns which included evidence of revised medicines management and repeat prescribing policies.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Three of the ANPs had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.
- We reviewed eight personnel files which included locum GPs and ANPs and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.
- The practice held evidence of Hepatitis B status and other immunisation records for clinical staff members who had direct contact with patients' blood for example through use of sharps.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. We saw examples of these rotas during our inspection and saw that adequate staffing levels were in place on a daily basis.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

Inadequate

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

There was a system in place within Leicester, Leicestershire and Rutland CCGs for all urgent care services including some emergency services such as East Midlands Ambulance Service (EMAS) whereby these providers had access to twice daily calls with other urgent care providers to discuss and monitor patient demand and capacity. These providers worked together in cases of high demand on services and put emergency plans into place to ensure effective use of these services within LLR. We were told that providers would advise patients should there be better capacity available at other local urgent care services and would give patients the option of attending alternative services if they wished to do so.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The walk in centre operated under a commissioned agreement to see 667 patients per month, equivalent to 8,004 a year. In 2015-16 19,600 patients were seen. There was one key performance indicator in place between the local CCG and the walk in centre which was to ensure 90% of patients to be seen within 30 minutes of arrival at the walk in centre. The practice continually achieved this KPI throughout the past 12 months, we saw evidence to show that the achievement for January-March 2017 was 97% compared to October-December 2016 when the practice achieved 98%. Staff informed us that when the practice had achieved the required number of patients to be seen per week as per the agreed KPI requirement, they had a duty of care to patients and never turned patients away to ensure that acutely ill people or children would be seen regardless.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. Overall exception reporting rate was 13% which was higher than the CCG average of 8% and the national average of 10%.

Performance for QOF and other clinical targets was comparable to CCG and national averages in most respects. Data from 2015-16 showed:

- Performance for diabetes related indicators was 76% which was lower than the CCG average of 86% and the national average of 90%. (exception reporting rate was 14% which was higher than the CCG average of 8% and the national average of 12%).
- Performance for mental health related indicators was 100% which was the maximum amount of points available compared to the CCG average of 93% and the national average of 93%. (exception reporting rate was 12% which was similar to the CCG average of 11% and the national average of 11%).

There was evidence of some clinical audits carried out however not all audits carried out had been used to support quality improvement. For example:

- There had been two full cycle audits carried out. One audit we looked at was an audit of patients prescribed glyceryl trinitrate spray (GTN) whilst being prescribed other medicines. (GTN is prescribed for chest pain associated with angina). The purpose of this audit was to assess the appropriateness of prescribing and to check these medicines were not issued as a repeat item for patients. The first cycle audit had identified a number of patients who were prescribed this medicine as a repeat item. The practice contacted these patients and advised them that this medicine would no longer be prescribed as a repeat item and would be changed to an acute item. A second cycle audit completed showed no further patients were prescribed this medicine as a repeat item. Two other first cycle audits had been carried out in relation to minor surgery procedures and one other medication audit. The practice had also commenced non-clinical related audits such as an audit in relation to appointment capacity and demand and an audit of did not attend (DNA) rates for patients to enable the practice to monitor access and availability of appointments and staffing requirements.
- We saw documented evidence that a discussion had taken place during a clinical meeting in November 2016 that after death audits were to be carried out on patients recently identified as deceased. However, there was no evidence to show that these audits had been

completed. We were also informed during our inspection that a patient had suffered a recent unexpected death, however an after death audit had not been completed at the time of our inspection.

- There was a lack of evidence to show that clinical audits had led to improvements being made, or actions implemented and monitored. For example, there was a lack of effective medicines audits in place to ensure prescribed high risk medicines were monitored appropriately to ensure the safe prescribing of medicines.
- During our inspection, we saw evidence that some patients were not on the correct clinical register within the electronic patient care record system to ensure patients received the correct reviews and were monitored appropriately. For example, those patients who were receiving palliative care and patients who suffered with depression. There was no system in place to monitor these registers. Following our inspection, we were provided with details of an audit of specific patient care records which had been carried out to ensure these care records and clinical read coding was up to date and accurate. We were also told that staff were to receive clinical read code training in April 2017 and that the process for medical review of incoming clinical correspondence would be reviewed.
- The practice did not have a system in place to ensure that an accurate, complete and contemporaneous record was maintained for every patient. During our inspection, we noted details of home visits required which did not have a home visit consultation added to the patient care record. When we asked if these home visits had taken place, the clinician was unable to advise if they had been carried out our not. Therefore, the clinician was unsure if the care record was up to date and accurately reflected the care and treatment of those patients. Following our inspection, we were provided with an action plan to address concerns raised during our inspection. This action plan told us that a system had been implemented to monitor home visit appointments to ensure home visit consultations were recorded.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The practice had a comprehensive induction programme in place for locum clinical staff which included a locum welcome pack.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff employed by the practice received an annual appraisal by the practice manager. Nursing staff appraisals were carried out jointly by the practice manager and an ANP. Nursing staff who were employed by a medical staffing agency received an annual shift appraisal at the practice by their employing agency. Nursing staff told us that they received monthly peer reviews by other ANPs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Inadequate

Are services effective?

(for example, treatment is effective)

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 55%, which was lower than the CCG average of 67% and the national average of 73%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to five year olds ranged from 82% to 94%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. For example, 52% of female patients aged 50-70 years of age had attended for breast cancer screening within six months of invitation months compared to the CCG average of 72% and the national average of 73%. 41% of patients aged 60-69 years of age had been screened for bowel cancer within six months of invitation compared to the CCG average of 43% and the national average of 56%. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. In November 2016, the practice was awarded a 'Best Practice' award for its high uptake of NHS health checks compared to other practices locally.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by either a male or female clinician.

All of the 51 patient Care Quality Commission comment cards we received were positive about the service experienced, one comment card although it contained positive comments, also referred to long waiting times for appointments following arrival at the practice. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 97%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 85%.
- 86% of patients said the nurse was good at listening to them compared with the CCG average of 87% and the national average of 91%.
- 90% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 93% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared with the CCG average of 83% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.
- 85% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 90%.

Good

Are services caring?

- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 48 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- A system of initial assessment was used to assess walk-in patients and ensure they had attended the correct service. Reception staff asked patients what their concern was and prioritised them on the basis of their need. For example, children were prioritised for an appointment.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.

Access to the service

The GP practice was open from 8am until 6.30pm, Monday to Friday. The walk in centre was open from 8am until 8pm seven days per week for anyone entitled to NHS services, whether registered with the practice, another GP practice or not NHS registered at all. They also provided services to overseas visitors. In addition to pre-bookable appointments that could be booked up three months in advance, urgent appointments and telephone consultations were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages with the exception of waiting times to be seen which were lower than local and national averages. For example:

- 91% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 75% of patients said they could get through easily to the practice by phone compared to the CCG average of 68% and the national average of 73%.
- 76% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 79% and the national average of 85%.
- 87% of patients said their last appointment was convenient compared with the CCG average of 90% and the national average of 92%.
- 81% of patients described their experience of making an appointment as good compared with the CCG average of 68% and the national average of 73%.
- 41% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 51% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. We were also told that patients who were registered with the practice could be seen in the walk in service if they presented at the practice and requested an on the day routine or urgent appointment.

We saw data that indicated during April 2015 to April 2016, the walk in centre saw 19,600. During a six month period from September 2016 to February 2017, the walk in centre saw 12,233 patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

We looked at documentation relating to seven complaints received within the past 12 months and found that most of these complaints with the exception of one had been fully investigated and responded to in a timely and empathetic manner. However, some complaints we looked at may have constituted a significant event analysis and we did not see evidence that this had taken place. The practice did not have a system in place for all staff including non-clinical staff to learn from complaints through discussion at regular meetings or via direct feedback.

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 told us they had a clear vision to deliver high quality care and promote good outcomes for patients.

The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.

Governance arrangements

The practice governance framework and clinical governance structure was ineffective and did not support the delivery of the strategy and good quality care. For example:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas such as minor illness, minor injury, diabetes and cervical cytology.
- There was a lack of clinical governance and oversight in place to ensure the safe care and monitoring of patients and management of risk.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly. We looked at 15 policies during our inspection and saw that these were reviewed and updated on a regular basis and were accessible to all staff electronically.
- Minuted, clinical meetings were held on a weekly basis which provided an opportunity for staff to learn about the performance of the practice. However, there was a lack of formal meetings in place to ensure non-clinical staff were able to attend to ensure they were updated about practice performance. Non-clinical staff did not have the opportunity to attend meetings where significant events, incidents and complaints may have been discussed to ensure actions taken or lessons learned were shared with them.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effective. There was not an effective system or process in place to ensure patients prescribed high risk medicines were reviewed and monitored appropriately to ensure safe prescribing of their medicines in accordance with best practice guidance.

Leadership and culture

On the day of inspection, we found that there was a lack of clinical oversight for some aspects of the service. However, when we fed back our concerns on the day of inspection, the lead GP and management team demonstrated they had the willingness to run the service and to take appropriate steps to ensure patients remained safe. Immediately following our inspection, we were provided with an action plan and assurance that issues highlighted during our inspection would be addressed with immediate effect.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The provider encouraged a culture of openness and honesty.

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted regular multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held weekly clinical team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the lead GP and the practice manager in the practice. However, not all staff were involved in discussions about how to run and develop the practice to ensure all members of staff had the opportunity to identify opportunities to improve the service delivered by the practice.

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

Are services well-led?

Inadequate

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- the practice in-house, quarterly patient satisfaction surveys and through complaints received. The practice did not have an active PPG in place, and told us that due to the contracts being continuously extended and undergoing a procurement process, that it was difficult for the practice to encourage patients to engage and attend regular PPG meetings due to the uncertainty around the procurement process and the future of both services.
- the NHS Friends and Family test, complaints and compliments received.
- staff through appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. For example: The practice did not ensure the safeguarding register was up to date and accurate and monitored regularly. The processes in place to review and monitor patients prescribed high-risk medicines was inconsistent. The practice did not carry out regular medicines audits. The practice did not ensure patient care records were factually accurate and represented the actual care and treatment of patients. Some patients were not on the correct clinical register within the electronic patient care record system to ensure patients received the correct reviews and were monitored appropriately. The process in place for acting on and monitoring significant events, incidents, near misses and complaints was ineffective. Reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. **How the regulation was not being met:** There was a lack of clinical governance and oversight in place to ensure the safe care and monitoring of patients and management of risk. Clinical audits in place were not used to support quality improvement, after deaths audits had not been completed. The practice did not carry out regular medicines management audits. The practice did not ensure that an accurate, complete and contemporaneous record was maintained for every patient. There was a lack of formal meetings in place to ensure non-clinical staff were able to attend to ensure they were updated about practice performance. Non-clinical staff did not have the opportunity to attend meetings where significant events, incidents and complaints may have been discussed to ensure actions taken or lessons learned were shared with them. These matters are in breach of regulation 17(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.