Swanpool Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Swanpool Medical Centre on 9 June 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, responsive and well led services and good for providing a caring service. It also required improvement for providing services for the six population groups (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 and people experiencing poor mental health (including people with dementia). This is because the concerns that have led to the overall provider rating apply to everyone using the practice, including these population groups.

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

- At the time of the inspection Swanpool Medical Practice was in a transitional phase following a recent merger of two former practices. The practice was reliant on locum GPs to provide the clinical services at the practice. The principal GP also ran three practices and was a salaried GP at a fourth practice. Within this context the main challenge has been to develop robust governance arrangements.
- The provider had not correctly registered the practice with the Care Quality Commission. The practice was registered as a sole provider but at the inspection told us that the practice was a partnership.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded but did not always demonstrate clear learning which was shared among staff.
- Risks to patients were assessed and managed, but assessments were not always robust including those relating to fire and staffing.

Summary of findings

- There was a lack of current published national data relating to patient outcomes due to the merger of the two former practices at Swanpool Medical Centre in June 2014 but early indications from practice data appeared to be showing good progress.
- Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Patient feedback about the service was mixed. Satisfaction with the service and quality of consultations was generally in line with the Clinical Commissioning Group (CCG) average but below the national average.
- Information about services and how to complain was available but the practice did not operate a robust complaints system to ensure complaints were appropriately managed.
- Patients had reported access to appointments was difficult and the practice had responded to this through increased sessions.
- Governance arrangements were not robust to ensure important issues affecting the practice were routinely discussed with staff.
- The practice had sought feedback from patients.

The areas where the provider must make improvements are:

- Ensure robust governance arrangements are in place for the management of quality and safety. Including systems to ensure important information is routinely discussed and shared with staff and actions identified implemented to improve the service provided. This would include management of significant events, complaints, safety alerts, audits, best practice guidance and the management of risks relating to fire safety and staffing.
- Ensure appropriate recruitment information is maintained for staff employed.
- Ensure audits undertaken are full audit cycles to demonstrate improvements made and that the findings are shared to deliver those improvements.
- Ensure a robust complaints process is in place which is consistently followed.

In addition the provider should:

- Ensure systems are in place for maintaining an accurate audit trail for prescriptions.
- Review arrangements to ensure patient dignity is not compromised in using grilles at reception.
- Ensure staff are aware of systems for sharing information with the out-of-hours provider.
- Ensure staff have an awareness of the Mental Capacity Act (2005) and how it applies to their role.
- Maintain robust systems for checking and recording checks of emergency equipment to provide assurance that they have been done and the equipment is fit for use.
- Develop systems for maintaining staff training records so that the practice can be assured that training relevant to staff roles have been completed and any identified development needs met.
- Ensure policies and procedures are understood by staff and embedded within the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the management of risks relating to staff, training and fire safety.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. There was limited comparative data available about the practice relating to patient outcomes although where available the practice appeared to be making positive progress. There was little reference made to national guidelines in treatment approaches and no formal systems for discussing new guidance. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice similar to and in some cases slightly lower than others for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However, this was not consistently demonstrated. A decision to use grilles at reception had been taken following an incident but no risk assessment had been undertaken or alternatives explored to ensure this did not compromise patients' dignity. Information for patients about the services was available and accessible to patients.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. During the last year the practice was in a transitional phase following the merger of two practices in June 2014, this had therefore been the main focus of the practice. The practice had started to identify the needs of the patients and following feedback had sought to improve access to services. The

Summary of findings

practice had good facilities and were accessible to patients' needs. Patients could get information about how to complain in a format they could understand. However, complaints were not always managed in a timely and consistent way with evidence that learning from complaints had been shared with staff.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. The practice had undergone a merger of two practices in June 2014 and had yet to develop a clear vision and strategy. The practice relied on locum GPs to cover clinical sessions. Staff were aware who they needed to go to for support but there were not robust governance arrangements in place. The principal GP had other work commitments and systems for discussing and sharing important information with all staff were limited. The practice had a number of policies and procedures to govern activity, but these were not practice specific. The practice proactively sought feedback from patients and had an active patient participation group (PPG). Many of the staff including locum GPs had worked in the former practices and the appraisal system was in progress for all staff to discuss their performance. Staff had opportunities for continuing professional development and attended CCG events.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people.

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

The practice had allocated named GPs to patients over 75 years and care plans were in place for those with complex health needs. Medication reviews were regularly carried out. Flu vaccines and shingles vaccines were offered to eligible patients. The practice held multidisciplinary team meetings to support those with end of life care and offered dementia screening. Home visits were undertaken for those who needed them.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long term conditions.

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Patients with long term conditions received regular reviews of their condition and medicines and those with the most complex needs had care plans in place. Home visits were available for patients who needed them. Flu vaccinations were offered to those in high risk groups.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for families, children and young people.

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw joint working with the health visitor and the midwife worked from the premises three days a week.

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Working age people (including those recently retired and students)

Requires improvement 

The practice is rated as requires improvement for working-age people (including those recently retired and students).

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

In response to patient feedback the practice had increased the number of sessions available to patients. Appointments and prescriptions could be booked on-line for greater convenience. However, the practice did not provide any extended opening hours. The practice offered a range of health promotion and screening services such as health checks for patients aged 40 to 75 years and cervical screening. Patients also had access to smoking cessation and counselling services which were available at the practice

People whose circumstances may make them vulnerable

Requires improvement 

The practice is rated as requires improvement for people whose circumstances make them vulnerable.

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group. The practice held a register of patients living in vulnerable circumstances including those with a learning disabilities. It had carried out annual health checks for people with a learning disability, practice data showed 84.4% of patients on this register had been reviewed during 2014/2015. The practice also registered asylum seekers at the request of the home office.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities for information sharing, documentation of safeguarding concerns and how to contact relevant agencies. Information was available to support patients to access other services for example support for carers.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for people experiencing poor mental health (including people with dementia).

This is because the provider was rated as requires improvement overall. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Practice data showed 82% of patients experiencing poor mental health had received a review during 2014/15. Screening for

Summary of findings

dementia was carried out at the practice to identify patients with early onset so that appropriate referrals could be made. Counselling services were available from the practice premises for those who would benefit from them.

Summary of findings

What people who use the service say

As part of the inspection we spoke with eight patients who used the practice. This included two members of the patient participation group (PPG). PPG are a way in which practices can work closely with patients to improve services. We also sent the practice comment cards prior to the inspection inviting patients to tell us about the care they had received. We received 11 completed comment cards. Our discussions with patients and feedback from the comment cards told us that patients were generally happy with the service they received. Patients told us that they were treated with dignity and respect and felt listened to. There was a mixed response from patients in relation to access.

Results from the GP national patient survey (July to September 2014) showed overall patient satisfaction scores for the practice were lower than other practices nationally but in line with the CCG area. The data from the survey related to the period following the practice merger but may relate to the former practices. Other areas including access and experience of consultations were also below the national average but similar to the CCG averages. The practice had recently undertaken an in-house survey in which similar findings were identified.

Areas for improvement

Action the service MUST take to improve

- Ensure robust governance arrangements are in place for the management of quality and safety. Including systems to ensure important information is routinely discussed and shared with staff and actions identified implemented to improve the service provided. This would include management of significant events, complaints, safety alerts, audits, best practice guidance and the management of risks relating to fire safety and staffing.
- Ensure appropriate recruitment information is maintained for staff employed.
- Ensure audits undertaken are full audit cycles to demonstrate improvements made and that the findings are shared to deliver those improvements.
- Ensure a robust complaints process is in place which is consistently followed.

Action the service SHOULD take to improve

- Ensure systems are in place for maintaining an accurate audit trail for prescriptions.
- Review arrangements to ensure patient dignity is not compromised in using grilles at reception.
- Ensure staff are aware of systems for sharing information with the out-of-hours provider.
- Ensure staff have an awareness of the Mental Capacity Act (2005) and how it applies to their role.
- Maintain robust systems for checking and recording checks of emergency equipment to provide assurance that they have been done and the equipment is fit for use.
- Develop systems for maintaining staff training records so that the practice can be assured that training relevant to staff roles have been completed and any identified development needs met.
- Ensure policies and procedures are understood by staff and embedded within the practice.

Swanpool Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a practice manager.

Background to Swanpool Medical Centre

Swanpool Medical Centre is a registered location of the single handed provider Dr Devanna Manivasagam. Swanpool Medical Centre provides primary medical services to a population of approximately 8,500. However, during the inspection Dr Devanna Manivasagam told us that the provider for Swanpool Medical Practice was a partnership of three GPs. The registration with the Care Quality Commission (CQC) is therefore incorrect. Dr Devanna Manivasagam has told us that he will correct the registration with CQC. Dr Devanna Manivasagam is also the sole provider for two other practices within the West Midlands: Bean Road Medical Practice and Stone Cross Medical Centre. Bean Road Medical Practice has also been inspected by CQC.

Swanpool Medical practice was a merger between the two former practices which operated from the premises under different providers. The merger took place in June 2014. The service at Swanspool Medical Practice is predominantly provided by three long term locum GPs (two are male and one is female). Two of the locum GPs were previously salaried GPs at the former GP practice. The partners work some sessions but not on a regular or routine basis. Their main roles are administrative. Other practice staff includes four practice nurses and a health care assistant employed through the CCG (all female). Non clinical staff includes a practice manager and a team of administrative and reception staff.

As of the 1 April 2015 the practice holds a general medical service (GMS) contract with NHS England. Under the GMS contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care. The practice also offers minor surgery.

The surgery opening times are 8.30am to 6.30pm daily with appointments available with a GP or nurse throughout the day.

The practice does not offer any extended opening hours . A pain clinic is held on a Saturday morning.

When the practice is closed out of hours services are provided by another provider.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 June 2015. During our visit we spoke with a range of staff (including GPs, nursing, management and administrative staff) and spoke with six patients who used the service. We looked at a range of documents that were made available to us relating to the practice, patients care and treatment. We also spoke with patients who used the service. Prior to the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 11 completed cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

It was not clear from the evidence seen that safety was a high priority within the practice. Systems were not sufficiently robust to ensure safety information was actively used to improve services. Staff we spoke with were aware of the need to report incidents but were not clear of the processes involved in doing this. Staff told us they would raise any concerns with the practice manager or principal GP. Governance arrangements did not support regular discussion of incidents and complaints to ensure effective action was taken to reduce the risk of reoccurrence. Following the inspection the practice manager advised us that staff had received training in using the systems for recording incidents.

Learning and improvement from safety incidents

The practice systems for reporting, recording and monitoring significant events, incidents and accidents was not robust. We reviewed records of nine significant events that had occurred during the last 12 months. Senior staff told us that significant events and incidents were discussed at practice meetings. However we found little evidence that significant events were formally discussed with practice staff to ensure learning took place and to review actions taken. Staff meetings were infrequent and had no clear agenda as to what was discussed. However, we did see evidence of a significant event that had been discussed and shared with the CCG relating to an acutely ill child. The child had been seen at the practice but attended accident and emergency. The outcome from this was that the GP had acted appropriately in this situation.

The practice manager told us about the electronic system that was used for reporting incidents or concerns and we also saw incident forms available. From the information recorded we could not verify that significant events were managed in a timely way, who had been involved in the investigation or that actions were followed up to ensure they had been implemented. There was a lack of evidence to show that the learning from incidents had been shared with staff to minimise the risk of reoccurrence and staff we spoke with were unable to provide any recent examples which had been shared with them.

National patient safety alerts were placed in a folder for practice staff to review, sign and act upon as appropriate. Staff we spoke with were aware that it was their responsibility to check the file and take any action needed. However, evidence available showed that safety alerts had not been reviewed by all relevant staff to identify if action was needed. Staff we spoke with were not able to provide any examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had some systems to manage and review risks to vulnerable children, young people and adults. There were no overall training records available to determine whether all staff were up to date with their safeguarding training. We looked at the individual training records for eight members of staff and found no records of safeguarding training for two members of clinical staff. However, clinical staff we spoke with were aware of their responsibilities to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies. One member of staff told us about a recent referral they had made to the local authority who are responsible for investigating safeguarding concerns. Contact details were easily accessible.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children who was trained to an appropriate level. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records and staff were able to show us this. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement with health visitors to discuss vulnerable children at the practice. Staff told us that there were systems in place to follow up children who did not attend for their immunisations.

There was a chaperone policy in place. Notices were visible in the waiting area to ensure patients were aware that they could request a chaperone to be present during their consultation. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Staff told us that chaperoning was usually undertaken by the nursing staff who demonstrated an understanding of

their responsibilities for this. However, we received conflicting information as to whether reception staff undertook chaperoning duties. A receptionist who told us that they had acted as a chaperone said they had not done so for a long time. We saw that reception staff did not routinely have Disclosure and Barring Service (DBS) checks. (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) and no risk assessments were in place for staff to assess the risk of non-clinical staff undertaking such duties.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice policy for ensuring that medicines were kept at the required temperatures and action to take in the event of a potential failure was non-practice specific and gave very little detail about local arrangements for managing a potential failure. However, nursing staff were able to provide examples of appropriate action and follow up taken in the event of potential failure. Records showed fridge temperature checks were carried out which ensured the medication was stored at the appropriate temperature.

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

Prescriptions seen that were awaiting collection had been reviewed and signed by a GP before they were given to the patient. Blank prescription forms for hand written prescriptions were securely stored. However, there were no robust systems for tracking the location of prescriptions removed from storage to provide a clear audit trail.

There was a system in place for the management of high risk medicines such as methotrexate and lithium. We looked at 10 records, nine showed appropriate management of patients prescribed the medicine. However in one incident there was evidence of a prescription being issued without checking blood results. We were told this was because they were unable to access the results from the hospital at the time.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs for the nursing staff that were signed and up to date. The health care assistant did not administer vaccines at the practice.

The practice held some controlled drugs on site (medicines that require extra checks and special storage arrangements because of their potential for misuse). The practice told us that they had stopped holding controlled drugs and stocks in place were waiting to be destroyed. The practice nurse explained that an official pharmacist had been requested to ensure appropriate disposal. The controlled drugs were stored appropriately and records were maintained of the stock.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The flooring had recently been replaced and was in good condition to enable easy cleaning. We saw there were cleaning schedules in place in each room detailing cleaning undertaken. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Personal protective equipment including disposable gloves, aprons and coverings were available in clinical areas and wipes for cleaning surfaces and equipment were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Practice staff told us that the infection control policies were available on the practices computer system.

The practice had a lead nurse for infection control who had last undertaken further training in 2013 for this role. There was no evidence of any recent infection control training or up dates for any of the other practice staff and the induction policy did not specify the inclusion of infection control. We saw evidence that the lead had carried out an infection control audit and a hand washing audit in the last 12 months. Actions had been identified and the practice manager advised on the progress of these. However, there was no formal action plan, named person accountable for delivering the action or a date for completion. This did not

ensure that actions identified through audits were being consistently followed up. There was no evidence of any dissemination of the audit findings among practice staff or formal routes for doing so.

The practice maintained records of the immune status of its clinical staff but those seen were not complete and up to date. For example one report indicated the member of staff was covered for hepatitis B for five years but the report was dated 2006. The print out of the immune status for hepatitis B for another member of staff was not clearly legible and another was missing. This information is important to ensure appropriate action is taken in the event of a sharps or needle stick injury to protect both patients and staff. Following our inspection the practice manager forwarded us up to date copies of the immune status for all three members of staff.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing basins with hand soap, gel and towel dispensers were available in treatment rooms. There was also hand gel available for patient use.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that legionella inspection had been undertaken on the premises prior to the practice merger in June 2014.

Equipment

Staff we spoke with told us they had equipment needed to enable them to carry out diagnostic examinations, assessments and treatments. We saw that several items of new equipment such as blood pressure monitors and scales had been purchased. We saw evidence that equipment was tested and maintained regularly and records were available that confirmed this. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in March 2015. However, this did not included the IT equipment. Staff told us this was the responsibility of the Clinical Commissioning Group (CCG). We also saw evidence of calibration of relevant equipment; for the defibrillator, ECG equipment, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice manager told us that there had been no new staff employed since the practice merged last year or in the last seven years. Prior to the merger human resources were outsourced to another provider but was now back under the practice. Recruitment information about existing staff had been returned to the practice but this was limited. We looked at staff files for the three locum GP staff, two practice nurses and two reception staff. Information in the files was not consistently available for example proof of identification and references. While information relating to professional registration was collected at recruitment there were no systems in place to check this remained up to date on an ongoing basis. There were checks in place through the Disclosure and Barring service (DBS) for clinical staff (These 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). There were no DBS checks in place for non-clinical staff and no risk assessments in place to identify whether this was required in relation to their roles.

The service was predominantly provided by locum GPs. Two of the locum GPs had worked for the practices that had merged and had changed their working arrangements as a salaried or partner to locum working arrangements. The principal GP at the practice who was also the provider told us that they would cover GP absences as would their partner who was not named on the practice's CQC registration. The principal GP was also the provider for two other practices in the West Midlands. The practice manager explained that there was not usually any difficulty in providing cover for each other and that since the merger there were enough staff to do this.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice were not robust. We saw evidence of some monitoring arrangements in place for example equipment, monitoring of fridge temperatures and cleaning to ensure they were carried out. The practice manager spoke about recent refurbishment that had taken place to the premises but could not evidence that regular checks of the building

or the environment were undertaken to identify any maintenance or other issues affecting the premises. The practice had a health and safety policy and we were told that the health and safety representative was the lead GP.

The identification of risks to the practice was limited. We saw there were risk assessments undertaken in relation to fire, asbestos, legionella and the control of substances hazardous to health. However, some of these had been undertaken prior to the practice merger and evidence to demonstrate what action if any had been undertaken to mitigate the risks identified was limited. We did not see any evidence of risks associated with the practice being discussed or reviewed with relevant staff.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. There was no overall list to monitor and verify whether all staff were up to date with their basic life support training. Five out of the seven staff records we reviewed showed evidence that training was completed and up to date. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). All staff asked knew the location of this equipment. No records were maintained for checks on the emergency equipment although nursing staff who carried out these checks confirmed they were undertaken on a daily basis. We checked and saw that the pads for the automated external defibrillator and the oxygen cylinder were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice nurse maintained a record in their diary of checks to show emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of computer system, absence of the senior partner and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of gas, electric or water companies in the event of an emergency. The plan was last reviewed in April 2015.

The practice had undertaken an in-house fire risk assessment however this was brief. We saw that fire exits and equipment were available. However, training records available did not show evidence that all staff had received fire training and the practice manger confirmed no routine fire drills were undertaken to ensure staff knew what to do in the event of a fire.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff took responsibility for ensuring that they reviewed and kept up to date in relation to best practice guidance. There were no clear processes for discussing and sharing new guidance such as those from the

the National Institute for Health and Care Excellence (NICE) and from local commissioners. Responses from staff in relation to how this information was shared was vague and inconsistent. We therefore found it difficult to ascertain the rationale for staff approaches to treatment and assessing patients' needs.

Staff described how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

We asked if any of the staff led in specialist clinical areas. One GP led in pain control and ran pain clinics on Saturday mornings. The principal GP, who was also the provider, told us they led in clinical specialist area such as diabetes, heart disease and asthma. All clinical staff including nurses were involved in reviews of patients with long term conditions and conversations with patients who told us that they received regular reviews of their condition.

The practice told us that they had identified patients registered with the practice who were at high risk of admission to hospital and that they participated in the unplanned admissions enhanced service. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. Data available from the practice told us that 281 patients on the practice list had care plans in place. This related to 2% of the practice population with the most complex needs. The principal GP told us that they reviewed all hospital discharge letters received at the practice to identify if the patient needed to be seen. If the principal GP was absent one of the long term locums would undertake this task.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice used the information collected for the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). There was no recently published QOF data for the practice since the merger in June 2014 which allowed comparisons with other services nationally. However data from the previously merged practices showed outcomes compared well to the CCG average in many clinical areas. The practice also showed us some of the data it held for 2014/15 which showed progress was being made against some of the long term conditions; for example 92.6% patients with chronic obstructive pulmonary disease and 91.7% of patients with cardiovascular disease had been reviewed in the last 12 months.

The practice showed us examples of clinical audits that had been undertaken in the 12 months. These included audits of antibiotic use, wound care and minor surgery. None were completed audits in which the practice was able to demonstrate the changes resulting since the initial audit. The practice undertook minor surgery and told us that they had undertaken an audit in relation to this however information provided was a list of procedures rather than an audit against expected standards.

Patients we spoke with on repeat prescriptions confirmed they received regular medicine reviews. There were alerts on the system which showed when reviews were due. Data available from the practice told us that 90.4% of patients on four or more medicines had received a medicine review in the last year. As the practice had recently merged they were unable to provide any recent reviews of prescribing data.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending

Requires improvement

Are services effective?

(for example, treatment is effective)

mandatory courses such as annual basic life support and safeguarding. The GPs we spoke with told us that they were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). We saw evidence of this in staff files.

All staff undertook annual appraisals in which learning needs had been discussed. Overall staff confirmed that the practice was supportive of training and gave examples of training events and updates attended.

Practice nurses and health care assistants were aware of their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Nursing staff had attended sessions with the clinical commissioning groups which included update on various long term conditions.

There was a locum pack available to support locum GPs working at the practice. This included information about referral processes, medicine reviews and safeguarding information. This was signed by locum staff to show that they were aware of it. The practice had a whistleblowing policy however, not all staff were aware of it should they need to raise any concerns.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were designated staff in the practice with responsibilities for passing on, reading and acting on any issues arising these communications. Staff told us that they were up to date with scanning information onto patient records to ensure it was available to clinical staff.

There was no current data available relating to emergency admission rates and how the practice compared with other practices. As part of the unplanned admissions enhanced service the practice used an alert system on the patient record to identify those with complex needs. This helped ensure that patients discharged from hospital requiring a follow up were not missed.

The practice held multidisciplinary team meetings every two months to discuss patients with complex needs. For example, those with end of life care needs. These meetings were attended by district nurses, and palliative care nurses. Meetings also included the health visitor to discuss vulnerable children.

Information sharing

Staff were not consistently aware of the systems for sharing important patient information with other providers. For example, staff we spoke with were not aware of the systems in place for sharing information with the local GP out-of-hours provider.

Staff told us that if patients were referred to hospital as an emergency a letter would be provided to go with the patient. The practice had also implemented the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Information about the summary care record was available on the practice website which enabled patients to opt out of the scheme if they wished to.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were not fully aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Nursing staff told us that they would discuss any issues with the GPs. Reception staff told us that they would not arrange an appointment for a patient under 16 years on their own without discussing with the practice manager or a GP. Clinical staff were unable to provide any examples of situations in which a patient's best interests were taken into account where a patient did not have capacity to make a decision.

Requires improvement

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for minor surgical procedures patients' written consent was obtained. The consent form contained information about the procedures and post-operative information.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. These were carried out by the practice nurses. The nurses we spoke with told us that they would inform the GP if they detected any health concerns as a result of these checks and would encourage the patient to come and see the GP.

The practice provided additional support for patients who needed it to help maintain or improve mental, physical health and wellbeing. For example, smoking cessation services and counselling services were provided on site. Patients could also be referred to health trainers to support them to lead healthier lifestyles. Due to the recent merger of the practice there was limited data available. However the practice told us that during 2014/15 1313 patients were given advice or referred to a smoking clinic of which 110 patients had stopped smoking.

We saw that nursing staff were trained to provide cervical screening for patients. Staff we spoke with told us that they followed up patients that did not attend screening and alerts placed on patient records enabled staff to remind patients when they attended the surgery.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data available from the practice showed that 68% of patients had received an influenza vaccination in 2014/15.

The practice held a range of health information available for patients to take away from the practice and on the practice website including those with long term conditions, families and children.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (July to September 2014) and a survey of 120 patients undertaken by the practice and discussed with the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all these sources showed patient satisfaction with how they were treated was mixed. For example, data from the national patient survey showed the practice was rated lower than the national and CCG average for patients who rated the practice as good or very good (71% compared to 78% for the CCG and 86% nationally).

The practice was in line with the CCG average but below the national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 83% and national average of 88%.
- 78% said the GP gave them enough time compared to the CCG average of 80% and national average of 86%.
- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 89% and national average of 93%

As part of the inspection we spoke with eight patients who used the practice. Patients also completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards. Feedback from patients was mostly positive about the service experienced. Patients said they found staff were helpful and that they felt looked after. They said staff treated them with dignity and respect. Appointments and waiting times were the main issue raised by six patients.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms and staff were able to describe the steps they took to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

None of the patients we spoke with raised any concerns about confidentiality. We saw that some of the staff had signed confidentiality agreements. The reception desk was located close to the waiting area. Reception staff told us that they would use a spare room if a patient wished to discuss something in private. Additionally, 76% said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

The practice had metal grilles between the reception desk and patients. We observed a patient passing a specimen through the grilles which did not demonstrate a respect for patient dignity. We asked staff about this, they told us that there had been an incident a few months previously in which there had been a volatile situation and a patient had tried to pull the grilles off. Staff told us that they had been fearful of removing the grilles. We asked if there had been any other incidents and the practice manager told us that the last one they could recall was approximately 13 years ago. There had been no risk assessments in relation to the use of grilles despite a significant event being raised in relation to the incident. A risk assessment would help identify the most appropriate course of action for managing potentially difficult situations and the impact of decisions on patients dignity.

Care planning and involvement in decisions about care and treatment

Data available from the practice showed that 3% of patients had a care plan in place including those with complex health care needs.

The patient survey information we reviewed showed a mixed response from patients about their involvement in planning and making decisions about their care and treatment. For example:

- 81% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79% and national average of 82%.
- 65% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 71% and national average of 74%.

Good

Are services caring?

Of the patients we spoke with on the day of our inspection seven out of the eight patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened and that treatment options were explained in a way they could understand to support them to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients rated the emotional support provided by the practice as below the CCG and national average. For example:

- 74% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77% and national average of 82%.
- 68% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 75% and national average of 88%.

The patients we spoke with on the day of our inspection and the comment cards we received did not support the survey information. Patients responded positively when asked about the care and support they received from staff at the practice.

Patients who were carers were asked to identify themselves to the practice via an online form. There was also information about support available to them. The practice displayed a range of information to support carers and patients with long term health conditions.

There was information available on the practice website informing patients what to do in the times of bereavement. Staff told us that prior to the merger they sent bereavement cards to families who had suffered a recent bereavement but were not aware of any specific follow up now.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

During the last year the practice had gone through a transitional phase following the merger of two GP practices and was reliant on locum staff. We received a presentation at the start of the inspection from the principal GP who told us about the progress made to date and the challenges of bringing two practices together. This had been the main focus for the practice. Due to the newness of the partnership and lack of data it was therefore difficult to see how the practice was responding to the specific needs of the practice population. The principal GP told us that they had advertised for salaried GPs but had not received any response. They told us that they no longer closed for half day which benefited patients. Services such as pharmacy, counselling and phlebotomy services were offered on site for patient convenience.

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

Members of the patient participation group (PPG) told us that they had discussed appointments and waiting times with the practice and that there had been improvements made in these areas.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Data available showed that the majority of the practice population was white British and English Speaking. Access to translation services were available if needed and staff were able to give examples where they had been used. Information on the practice website could be translated into several different languages. A hearing loop was installed at the practice to support patients with hearing difficulties.

The practice was able to give examples of patients in vulnerable circumstances that had been registered including asylum seekers and travellers enabling them to receive health care with the practice.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were accessible toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. The practice also employed four practice nurses who were all female. This ensured patients had access to male and female clinicians.

Access to the service

The surgery was open from 8am to 6.30pm Monday to Friday. Appointments were available between 8.30am and 11.30am and 4pm to 6.30pm on weekdays. Appointments were available on the day for patients that needed to be seen urgently. Patients were also able to book appointments in advance and would be able to see their preferred GP if willing to wait.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was also provided to patients via the website.

The practice did not offer any extended opening hours. Staff told us that patients who might need a longer appointment could request longer appointments if needed but this was not formally advertised.

The GP national patient survey information we reviewed showed patient satisfaction and responses about access to appointments was consistently below both the CCG and national averages. For example:

- 69% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 57% described their experience of making an appointment as good compared to the CCG average of 66% and national average of 73%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 17% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 56% and national average of 73%.
- 59% said they could get through easily to the surgery by phone compared to the CCG average of 65% and national average of 71%.

We received a mixed response from patients about the appointments system. Most patients felt they would be able to see a doctor on the same day if their need was urgent and one patient told us that the practice would see children straight away. However six patients told us of difficulties they had accessing appointments.

The principal GP told us that they had increased the number of sessions and no longer closed half day to try and improve access since they had taken over the practice.

Listening and learning from concerns and complaints

The practice had a policy in place for handling complaints but this was not consistently followed. Systems in place for handling complaints and concerns at the practice were not robust and complaints had not been handled in a consistent way. 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. Complaints leaflets were available in the waiting room. Information on how to make a complaint was also included in the practice leaflet and on the practice website.

Only one of the patients we spoke with told us that they had ever raised a complaint. They told us that they had not been satisfied with the way it had been managed and that nothing had changed as a result.

We saw that there had been 16 complaints recorded in the last 12 months. All complaints were of a clinical nature. We were told that there had been numerous complaints in relation to access since the merger but due to the volume these had not been formally recorded. Complaints had not been consistently managed in a timely manner and those received by email had not been picked up when the practice manager had been absent during sick leave. We found in one instance where the a discussion with the patient had taken place with the GP following a complaint but the meeting had not been formally documented. Responses to patients were generally brief with no reference to the Parliamentary and Health Service Ombudsman should the patient not be satisfied with the response received.

Staff told us that complaints were discussed at practice meetings although we did not see any formal evidence of this. The practice was unable to provide evidence that complaints were routinely discussed with staff to ensure lessons were learnt. Staff told us that as a result of complaints relating to access two additional clinical sessions per week had been introduced.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had not formally developed a clear vision for the future. Staff all spoke consistently of their desire to provide a good service and patient care. However, the main focus had been on the amalgamation of two practices and working together as a team. The principal partner spoke of the challenges of bringing together two different teams and computer systems.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of these policies and procedures. These were standard policies. There was no formal evidence available to confirm staff had read and understood the policies in place.

Staff that we spoke with told us that they were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. However, we found some of the governance arrangements were not sufficiently robust to ensure information relating to performance, quality and risks were routinely discussed with all staff. Staff told us that the practice held staff meetings but gave conflicting information as to how frequently these occurred and related to some extent the difficulties in getting locum staff together. Minutes from these meetings showed practice meetings had been held approximately every three months. However, there was no clear agenda to ensure governance issues were routinely discussed.

The GP and practice manager took an active leadership role for overseeing the systems in place to monitor the quality of the service. This included using the Quality and Outcomes Framework to measure its performance. Data available from the practice in relation to QOF showed that total points achieved for 2014/2015 was 509 points out of the total of 559. The practice was unable to demonstrate that QOF data was regularly discussed with staff and action plans put in place where needed to maintain or improve outcomes.

Leadership, openness and transparency

The practice was led by the principal GP and staff told us that they referred to them for support. The principal GP in the practice also ran two other practices and was not always available on site. The principal GP told us that they were the lead for chronic disease management and safeguarding. We asked how they provided support when not available onsite and they told us that they came in every day and could be contacted by telephone which staff confirmed. The principal GP spoke about a partner in the practice but had not registered the practice as a partnership with the Care Quality Commission. The provider told us they would rectify this however, they also told us their partner was planning to retire although no date was given for this. Clinical staff generally worked independently with little evidence that they were involved in regular discussions on issues affecting the practice and had opportunities for sharing important information.

Seeking and acting on feedback from patients, public and staff

The practice encouraged feedback from patients. Information to encourage patients join the patient participation group was available on the practice website. Since the merger of two practices feedback had been gathered from patients through the patient participation group (PPG) and in-house patient survey. There were approximately six active members in the PPG and we spoke with two of them. They told us that they were trying to increase the membership of younger patients and we saw that the practice was trying to encourage all members of the community to join a virtual group. We saw that the last in-house patient survey relating to access had been discussed with the PPG. Although the practice had not specifically agreed a formal action plan members of the PPG told us the practice had fed back what they had done and that they had seen some improvement in waiting times. The results from these surveys were available on the practice website. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice was unable to clearly demonstrate that there were regular opportunities for staff to provide feedback about the service. Practice meetings were held every three months but otherwise there was no formal documentation of meetings in which staff could formally raise and discuss issues affecting the practice and of actions to take forward. We saw that since the merger nursing staff had received

Are services well-led?

Requires improvement

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

appraisals and that there had been a group appraisal with reception staff with the view to individual appraisals being undertaken shortly. Staff told us that they found the practice manager approachable if they needed to discuss something informally.

Management lead through learning and improvement

Staff we spoke with were generally happy with the support they received from the practice to maintain their clinical professional development. Staff told us about CCG events they attended and opportunities to network. We saw examples of in-house learning sessions had taken place relating to domestic violence to increase staff awareness.

The practice had completed reviews of significant events and other incidents but it was not clear from the evidence seen that this was a robust process which ensured learning and improved outcomes for patients. For example, there had been an incident involving an aggressive patient in which the practice had positively reviewed the handling of the incident but had not assessed if they could have done anything differently. As a result grilles were permanently in place at reception with no assessment of the risk.

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust systems to ensure patients were protected against the risk of unsafe or inappropriate care and treatment. Robust systems were not in place to ensure important information affecting the practice was routinely discussed and shared with all staff including significant incidents, complaints, safety alerts and new guidance to ensure they were appropriately acted on and that staff learnt from them. Systems were not in place to ensure best practice guidance was discussed and where appropriate implemented in practice. An effective audit process was not in place to ensure service improvement was delivered. Robust systems were not in place to identify and manage risks to patients and the service for example fire safety and staffing. Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Roles relating to non-clinical staff had not been risk assessed to identify the need for DBS checks. Information was not consistently available for staff employed to verify that they were of good character and suitable for the work performed. Registration with professional bodies for relevant staff was not routinely monitored to ensure it remained up to date.

This section is primarily information for the provider

Requirement notices

Regulation 19 (1)(a)(b) (3)(a) and schedule 3 Information required in respect of persons employed or appointed for the purposes of a regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not appropriately handle complaints in line with recognised guidance. Complaints were not managed in a consistent way.** **Regulation 16 (1)(2)**