OHP-Harlequin Surgery

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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Harlequin Surgery, formerly registered with CQC as Dr Ainsworth and Partners on 5 January 2017. The overall rating for the practice was good with requires improvement for the provision of safe services and the families, children and young people population group. The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Dr Ainsworth and Partners on our website at www.cqc.org.uk. In November 2017 the practice registered with CQC as OHP-Harlequin Surgery under the provider organisation Our Health Partnership.

This inspection was an announced focused inspection carried out on 9 January 2018 under the new provider organisation registration. The inspection was undertaken to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 5 January 2017. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Our key findings were as follows:

- We found the practice had fully addressed the breaches identified at our previous inspection in relation to the provision of safe services and for the families, children and young people population group.
- The practice had made significant improvement in the arrangements in place for safeguarding service users from abuse and improper treatment. Arrangements were comprehensive, well organised and included effective working relationships with other healthcare professionals.
- The practice had put in place formal systems to routinely review and monitor children on the at risk register. This had been extended to include others who may be at risk such as vulnerable adults.
- The practice had systems in place to ensure all electrical equipment was appropriately checked and safe for use.
- The practice had implemented effective systems to ensure safety alerts were appropriately managed and shared with relevant staff.

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

OHP-Harlequin Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and a GP specialist adviser to CQC.

Background to OHP-Harlequin Surgery

OHP-Harlequin Surgery is a member of the provider organisation Our Health Partnership, a partnership of approximately 40 practices providing primary medical services to approximately 340,000 patients across the West Midlands area. Our Health partnership aims to support the member practices in meeting the changing demands of primary care. The practice also sits within NHS Birmingham Cross City Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice has a General Medical Services (GMS). A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care and is a nationally agreed contract.

OHP-Harlequin Surgery is located in purpose built premises for the provision of primary medical services. The practice registered list size is approximately 11,600 patients. Based on data available from Public Health England, the practice is located within the 10% most deprived areas nationally. The age distribution of the practice population broadly follows that of the national average.

Practice staff consist of three GP partners (two female and one male) and two salaried GPs (both female), three Advanced Nurse Practitioners (ANPs), four practice nurses and three healthcare assistants (HCAs). Other practice staff include a practice manager and a team of administrative, reception and secretarial staff.

The practice is a training practice for qualified doctors training to be GPs. At the time of the inspection there were two GP registrars working at the practice.

The practice is open 8am to 6.30pm Monday to Friday and closes on a Wednesday between 12.30pm to 2.30pm. When the practice is closed patients are directed to the out of hours GP service provider through the NHS 111 telephone service.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Ainsworth and Partners, Harlequin Surgery on 5 January 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall with requires improvement for providing safe services and for the families, children and young people population group. The full comprehensive report following the inspection on 5 January 2017 can be found by selecting the 'all reports' link for Dr Ainsworth and Partners on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of OHP-Harlequin Surgery on 9 January 2018. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

Are services safe?

Our findings

At our previous inspection on 5 January 2017, we rated the practice as requires improvement for providing safe services as the arrangements in respect of routinely reviewing and monitoring children on the at risk register were not adequate. We also identified areas where the practice should improve which included ensuring computers were included in portable electrical equipment safety checks and for sharing learning and outcomes from safety alerts with all relevant staff.

These arrangements had significantly improved when we undertook a follow up inspection on 9 January 2018. The practice is now meeting legal requirements in relation to those areas previously identified.

Safety systems and processes

- The practice had systems to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. At this inspection we found the practice had taken significant action to strengthen those systems and processes. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. Information was also readily available to staff for guidance across a range of areas including child protection, vulnerable adults, domestic violence, female genital mutilation and labour exploitation. There was a named lead GP for child and adult safeguarding at the practice who was supported by one of the senior administrators. The practice worked with other agencies to support patients and protect them from neglect and abuse. This included attendance at joint case review meetings and the provision of reports as required for other relevant agencies. Regular multi-disciplinary team meetings with the health visitor and midwife had been instigated and embedded since our previous inspection and conversations with these community staff told us that the arrangements were working well, that there was good communication between the practice and that some of the systems now in place had been taken back to their own teams to try in other areas. All staff were able to raise any relevant issues or concerns at these meetings. The minutes seen from these meetings were detailed. The practice held risk registers for both vulnerable children and adult, these were comprehensive, reviewed regularly by the practice and members of the multidisciplinary team and rated according to the levels of concern and risk. The practice was able to give examples of positive action taken to help protect some of their most vulnerable patients.
- The practice provided evidence to show that all electrical equipment including computers had undergone portable electrical equipment safety checks. These had been carried out within the last 12 months.

Lessons learned and improvements made

- There was a system for receiving and acting on safety alerts and for sharing learning from them. We found improvements in the systems in place since our previous inspection. All clinicians were now registered to receive the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts individually and safety alerts were a standing agenda item for discussion at practice meetings. We saw evidence of action taken from three recent safety alerts.