Quincy Rise 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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Quincy Rise Surgery on 9 March 2016 and an announced focussed inspection on 4 April 2016. Overall the practice is rated as inadequate.

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

- Governance arrangements were not robust. Significant event records lacked key information. Minutes of meetings did not reflect a culture of learning and patient outcomes were hard to identify, as little or no reference was made to audits or quality improvement.
- We identified a number of gaps in the arrangements for identifying, recording and managing risks and we found many gaps in the record keeping for staff files. Appraisals were overdue for some members of staff and the practice did not have an induction pack for locum's clinicians to use when working at the practice.
- The arrangements for managing medicines, including vaccinations, were not robust to ensure that patients were kept safe.
- During our inspection we found that care plans were not in place across practice registers and that some records did not represent that adequate medication reviews had taken place. These included patients on the practices dementia, mental health, learning disability and palliative care registers.
- Staff demonstrated they understood their responsibilities and how to respond to a safeguarding concern; however we received mixed feedback with regards to identifying who the safeguarding lead was at the practice.
- Notices in the patient waiting room told patients how to access a number of support groups and organisations, however there was no information available to specifically support carers.

Summary of findings

- We observed a friendly atmosphere throughout the practice during our inspection. Although staff spoke positively about working at the practice, not all staff said that they felt supported.
- The practice did not have an action plan in place to demonstrate how improvements to the service could be made. For example, the practice had not reviewed their results from the national GP patient survey and no action plans were in place to improve appointment waiting times.
- We noticed that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone.

The areas where the provider must make improvements are:

- Ensure that safety alerts (such as medicines and medical device alerts) are effectively managed in the practice to ensure that action is taken where necessary in relation to patient safety alerts which impact on service users.
- Improve the overall management of Human Resources; ensure that the appropriate disclosure and barring (DBS) and recruitment checks have been completed for all staff as required, prior to working at the practice.
- Ensure that risk is assessed in the absence of DBS checks for members of the team who provide a chaperone service.
- Ensure that care plans are continually completed in line with patients needs and ensure that medication reviews are always part of patient's care and treatment assessments as required.
- Improve the arrangements for managing medicines including vaccinations; ensure that record keeping for the management of cold chain and Patient Group Directives (PDGs) reflect national guidance.
- Ensure that risk is assessed and managed in relation to premises, equipment and infection control to assure service users and staff that they are safe.
- Ensure that clinical audits including re-audits are completed to ensure improvements have been identified and achieved.
- Implement a plan of business continuity to support the practice in the event of a major incident.
- Engage with and respond to the views of service users and staff and put actions in to place to make improvements where possible.

The areas where the provider should make improvement are:

- Embed a culture of learning throughout the practice, ensure that key topics such as significant events, incidents and complaints are discussed with staff and recorded as best practice in order to share and monitor learning and action points and to continually apply improvements.
- Ensure that staff are aware of their own roles as well as the responsibilities of colleagues, including key roles such as the practice leads for safeguarding and infection control.
- Ensure staff are supported through a programme of regular appraisals.
- Improve governance arrangements in relation to infection control; ensure that actions are taken to address improvements identified through completed infection control audits. Keep records to support that medical equipment is appropriately cleaned and that the required cleaning has taken place for each area of the practice, including specific areas such as the cleaning of non-disposable curtains used in treatment rooms.
- Ensure that prescription pads used for home visits are adequately tracked and monitored in line with national guidance.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where

Summary of findings

necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General 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?

Inadequate

- We saw that significant events had been reported in the practice. Although records outlined the areas of concern and action taken, we found that key information was not documented such as the date from which the significant events had occurred and the practice could not demonstrate how learning was shared with staff.
- Staff demonstrated they understood their responsibilities and how to respond to a safeguarding concern; however during our inspection we received mixed feedback with regards to identifying who the safeguarding lead was at the practice.
- We found many gaps in the record keeping for staff files. There was no evidence of disclosure and barring checks (DBS checks) for staff and risk assessments were not in place for members of the reception team who occasionally acted as chaperones.
- The arrangements for managing medicines, including vaccinations, were not robust to ensure that patients were kept safe.
- There were some policies in place for the management of health, safety and fire. However, we found gaps across a number of areas in assessing, monitoring and mitigating risks to patients.

Are services effective?

Requires improvement

- The practice could not demonstrate that they had carried out any full cycle clinical audits. Patient outcomes were hard to identify as little reference was made to quality improvement.
- During our inspection we found that care plans were not in place for a proportion of patients across practice registers and where care plans were in place, records lacked sufficient detail.
- Appraisals were overdue for some members of staff and the practice did not have an induction pack for locum's clinicians to use when working at the practice.
- Records highlighted significant gaps in medication reviews, including overdue reviews of patients across a range of practice registers such as patients diagnosed with dementia and patients experiencing poor mental health.
- Staff explained that patient registers were regularly reviewed during the MDT meetings, including patients on the practices

Summary of findings

palliative care register, patients with a learning disability, patients who had been diagnosed with dementia and patients experiencing poor mental health. We saw some evidence of this in the minutes of the most recent MDT meeting.

Are services caring?

Good

- Notices in the patient waiting room told patients how to access a number of support groups and organisations, however there was no information available to specifically support carers.
- We observed a friendly atmosphere throughout the practice during our inspection. We noticed that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.
- Notices in the patient waiting room told patients how to access a number of support groups and organisations.
- The practice also provided information and supported patients by referring them to counselling services and further support organisations.

Are services responsive to people's needs?

Good

- Records demonstrated that complaints were satisfactorily handled and dealt with openness and transparency. However, complaints were not factored in to the minutes of practice meetings to demonstrate that learning from complaints was shared with the practice team.
- There were disabled facilities and translation services available. The practice did not have a hearing loop, staff we spoke with said that they did not have any deaf patients or any patients with hearing impairments.
- There were longer appointments available at flexible times for people with a learning disability, for carers and for patients experiencing poor mental health. Urgent access appointments were available for children and those with serious medical conditions.
- Results from the national GP patient survey published in January 2016 highlighted that the practice was below average with regards to appointment waiting times.

Are services well-led?

Inadequate

- The practice had some policies and protocols in place which were accessible to staff. The policies were practice specific and

had been reviewed. However, overall we found that governance arrangements were not robust. We identified a number of gaps in the arrangements for identifying, recording and managing risks.

- Significant event records and the minutes of meetings contained limited information and did not demonstrate a culture of learning. The practice did not review themes or trends from significant events and complaints.
- The practice had not reviewed their results from the national GP patient survey, no in-house survey had been conducted and therefore the practice did not have an action plan in place to demonstrate how improvements to the service could be made.
- Although staff spoke positively about working at the practice, not all staff said that they felt supported.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

- The practice is rated as inadequate for providing safe and well led services, requires improvement for providing effective services and good for providing caring and responsive services; this affects all six population groups.
- Clinical staff carried out home visits for older patients and patients who would benefit from these.
- The latest flu vaccination rates for the over 65s was 69%, compared to the national average of 73%.
- Staff explained that patients who were at risk of admission to hospital were reviewed and discussed as part of the practices multi-disciplinary team meetings (MDT) meetings.

People with long term conditions

Inadequate

- The practice is rated as inadequate for providing safe and well led services, requires improvement for providing effective services and good for providing caring and responsive services; this affects all six population groups.
- Flu vaccinations for those patients in the at risk groups was 51%, compared to the national average of 52%.
- We saw minutes of meetings to support that joint working took place and that patients with long term conditions and complex needs were discussed as part of the practices multi-disciplinary team meetings (MDT) meetings.
- Performance for overall diabetes related indicators was 97% compared to the CCG average of 88% the national average of 89%.

Families, children and young people

Inadequate

- The practice is rated as inadequate for providing safe and well led services, requires improvement for providing effective services and good for providing caring and responsive services; this affects all six population groups.
- Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for under two year olds ranged from 80% to 100% compared to the CCG averages which ranged from 40% to 100%. Immunisation rates for five year olds ranged from 89% to 97% compared to the CCG average of 93% to 98%.

Summary of findings

- The practice offered urgent access appointments were available for children, as well as those with serious medical conditions.

Working age people (including those recently retired and students)

Inadequate

- The practice is rated as inadequate for providing safe and well led services, requires improvement for providing effective services and good for providing caring and responsive services; this affects all six population groups.
- The practice's uptake for the cervical screening programme was 83%, compared to the national average of 81%.
- The practice offered extended hours from 6:30pm to 7pm on Tuesdays and from 6:30pm to 7:30pm on Thursdays for those who could not attend the practice during core hours.
- Appointments could be made in the practice, over the phone and online. There was a text messaging appointment reminder service available and the practice also used an electronic prescription service.

People whose circumstances may make them vulnerable

Inadequate

- The practice is rated as inadequate for providing safe and well led services, requires improvement for providing effective services and good for providing caring and responsive services; this affects all six population groups.
- The practice had four patients on their palliative care register. However, data provided by the practice highlighted that none of these patients had care plans in place.
- There were seven patients on the practices learning disability register. The practice shared a report which highlighted that only one of these patients had a care plan in place that no reviews had taken place within 12 months.
- Staff explained that vulnerable patients and patients on the practices learning disability and palliative care registers were reviewed and discussed as part of the practices multi-disciplinary team meetings (MDT) meetings.

People experiencing poor mental health (including people with dementia)

Inadequate

- The practice is rated as inadequate for providing safe and well led services, requires improvement for providing effective services and good for providing caring and responsive services; this affects all six population groups.

Summary of findings

- There were 19 patients and the practices mental health register and only four patients on the practices dementia. We found that most of these patients did not have a care plan in place.
- Performance for mental health related indicators was 84% compared to the CCG and national average of 93%. There were 19 patients on the practices mental health register. Four of these patients had care plans in place however we found that records lacked sufficient information to reflect adequate care plans. We also found that patients on the practices mental health register were not receiving regular reviews, such as medication reviews.
- There were only four patients on the practices dementia register. QOF data highlighted that diagnosis rates for patients identified with dementia were 100%, with an exception rate of 0%. Although the data provided by the practice highlighted that all patients on the practices dementia register had care plans in place, during our inspection on 9 March we found that records lacked sufficient information to reflect adequate care plans. Findings from our focussed inspection on 4 April highlighted that three of the four patients on the practices dementia register did not have a care plan in place. We also found that these patients were not receiving regular reviews, such as medication reviews.

Summary of findings

What people who use the service say

The practice received 110 responses from the national GP patient survey published in January 2016, 318 surveys were sent out; this was a response rate of 35%. The results showed the practice was performing in line or above local and national averages in some areas. For example:

- 91% found it easy to get through to this surgery by phone compared to the CCG average of 70% and national average of 73%.
- 88% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and national average of 85%.
- 88% described the overall experience of the practice as good compared to the CCG and national average of 85%.
- 84% said they would recommend their GP surgery to someone who has just moved to the local area compared to the CCG average of 76% and 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 spoke with four patients during our inspection. Patients commented that they were generally satisfied with the care provided by the practice and staff were described as friendly, helpful and caring. No comment cards were completed for the inspection.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure that safety alerts (such as medicines and medical device alerts) are effectively managed in the practice to ensure that action is taken where necessary in relation to patient safety alerts which impact on service users.
- Improve the overall management of Human Resources; ensure that the appropriate disclosure and barring (DBS) and recruitment checks have been completed for all staff as required, prior to working at the practice.
- Ensure that risk is assessed in the absence of DBS checks for members of the team who provide a chaperone service.
- Ensure that care plans are continually completed in line with patients needs and ensure that medication reviews are always part of patient's care and treatment assessments as required.
- Improve the arrangements for managing medicines including vaccinations; ensure that record keeping for the management of cold chain and Patient Group Directives (PDGs) reflect national guidance.
- Ensure that risk is assessed and managed in relation to premises, equipment and infection control to assure service users and staff that they are safe.
- Ensure that clinical audits including re-audits are completed to ensure improvements have been identified and achieved.
- Implement a plan of business continuity to support the practice in the event of a major incident.
- Engage with and respond to the views of service users and staff and put actions in to place to make improvements where possible.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Embed a culture of learning throughout the practice, ensure that key topics such as significant events,

incidents and complaints are discussed with staff and recorded as best practice in order to share and monitor learning and action points and to continually apply improvements.

- Ensure that staff are aware of their own roles as well as the responsibilities of colleagues, including key roles such as the practice leads for safeguarding and infection control.
- Ensure staff are supported through a programme of regular appraisals.
- Improve governance arrangements in relation to infection control; ensure that actions are taken to address improvements identified through completed infection control audits. Keep records to support that medical equipment is appropriately cleaned and that the required cleaning has taken place for each area of the practice, including specific areas such as the cleaning of non-disposable curtains used in treatment rooms.
- Ensure that prescription pads used for home visits are adequately tracked and monitored in line with national guidance

Quincy Rise Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Quincy Rise Surgery

Quincy Rise Surgery is a long established practice based in the Brierley Hill area of Dudley. There are approximately 3,200 patients of various ages registered and cared for at the practice. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The clinical team includes a lead GP, a GP partner, a salaried GP and two practice nurses. The lead GP and the practice manager form the practice management team and they are supported by a team of four receptionists.

The practice is open between 8am and 6pm Monday to Friday. Appointments are available between 9am 12pm and then from 4pm to 6:30pm. There is a GP on call each morning from 8am to 9am and during the afternoons when appointments are closed. The practice offers extended hours from 6:30pm to 7pm on Tuesdays and from 6:30pm to 7:30pm. There are also arrangements to ensure patients received urgent medical assistance when the practice is closed during the out-of-hours period.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

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

The inspection team:-

- Reviewed information available to us from other organisations such as NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection on 9 March 2016 and an announced focussed inspection on 4 April 2016.
- Spoke with staff and patients.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

During our inspection on 9 March 2016 we identified a number of gaps across the clinical and quality aspects of the effective care domain. Due to limited GP availability during our initial inspection, we returned to the practice on 4 April 2016 in order to gather further information with a practice GP where we focussed on gaps in information; specifically in relation to providing effective care to patients.

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

Staff we spoke with explained that significant events and incidents were verbally reported to the practice manager and the GP. Incidents and significant events were recorded by the practice manager once an incident had been identified or verbally reported by a member of staff in the practice.

We saw records of two significant events which had occurred during the last 12 months. Records outlined the areas of concern and action taken; however key information was not documented such as the date from which the significant event had occurred and how learning was shared. We also looked at records of staff meetings and found that significant events were not included in the minutes of the meetings to demonstrate that they were discussed with staff and that learning was shared.

We saw evidence of some safety alerts that were disseminated to and received by the clinicians, such as an alert for information regarding home visit protocols. However, staff we spoke with were unable to demonstrate how the practice had taken action on specific alerts such as medicines alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). The lead GP explained that the local Clinical Commissioning Group (CCG) pharmacist often ran a report in order for the clinicians to recall patients and take action where required in relation to specific safety alerts, however there was no evidence in the practice to support this. The most recent MHRA alert provided by the GP also dated back to May 2015 and therefore the practice could not demonstrate that they had received or taken action in relation to any MHRA safety alerts since May 2015.

Overview of safety systems and processes

- Safeguarding policies were accessible to all staff which outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice nurse was the lead member of staff for safeguarding and the practice manager was the deputy lead.
- Staff confirmed that they attended safeguarding training during March 2015 however records were not available to support this. Staff demonstrated they understood their responsibilities and how to respond to a safeguarding concern; however we received mixed feedback with regards to identifying who the safeguarding lead was at the practice. Staff explained that during the inspection there was a transition period in appointing a new safeguarding lead as the previous safeguarding lead had recently resigned from their post.
- Notices were displayed to advise patients that a chaperone service was available if required. The practice nurses would usually provide a chaperoning service. Occasionally some members of the reception team would act as chaperones. Staff members had been trained on how to chaperone.
- We found many gaps in the record keeping for staff files. We viewed three staff files and additionally checked to see if disclosure and barring checks (DBS checks) or formal risk assessments were in place for members of the team who provided a chaperone service. 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. We found that risk assessments were not in place for members of the reception team who occasionally acted as chaperones; in the absence of DBS checks. We also found that the practice did not have records of DBS checks on file for the practice nurses. Staff we spoke with explained that DBS checks had been completed externally for the practice nurses, as they also worked at a local hospital. However, the practice did not keep records to provide evidence and assurance that DBS checks had been completed.
- Additionally, the three staff files we viewed did not contain records to demonstrate that appropriate recruitment checks had been undertaken prior to employment, such as proof of identity and references. We asked to look at a total of five staff files and found that files were not available for one long term member of the reception team and that a staff file had not been produced for the lead GP who had been at the practice since approximately May 2015.
- One of the practice nurses was the infection control lead and although other staff were able to identify who the named lead was, when we spoke to the practice nurse they were unfamiliar with an official named lead in the practice. There was a protocol in place which outlined who the infection control lead was and we saw records

of a completed infection control audit which was carried out in June 2015. However, there was no evidence of the actions taken to address improvements identified specific to hand hygiene, including the development of a hand hygiene policy.

- We observed the premises to be clean and tidy. However, records were not kept to reflect the cleaning of specific medical equipment, such as the equipment used for ear irrigation. We also found that the templates used for cleaning specifications were not available in a completed format to demonstrate that the required cleaning had taken place for each area of the practice. Additionally, for specific cleaning requirements such as the cleaning of the non-disposable curtains used in the treatment rooms.
- We saw that clinical equipment was calibrated to ensure that the equipment was checked and working properly. Staff had access to personal protective equipment including disposable gloves, aprons and coverings. There was a policy for needle stick injuries and staff knew the procedure to follow in the event of an injury.
- There were systems in place for repeat prescribing and a system in place for the prescribing of high risk medicines. However, some records we viewed pertaining to patients experiencing poor mental health and for patients with dementia highlighted that although records were coded to demonstrate that medication reviews had taken place within a 12 month period, the records of these reviews did not reflect the process of an adequate medication review. The practice used an electronic prescribing system. Prescription pads were used for home visits and these were stored securely, however the practice did not have a system in place to track and monitor their use.
- The arrangements for managing medicines, including vaccinations, were not robust to ensure that patients were kept safe. For example, the vaccination fridges were well ventilated and secure, however during our inspection we found that only the actual fridge temperatures were recorded daily; the minimum and maximum fridge temperatures were not recorded and therefore staff were not following guidance by Public Health England. The practice nurse administered vaccines using patient group directions (PGDs). PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of PGDs and evidence that the practice nurses had received appropriate training to administer vaccines. However, some of the PGDs had not been signed by a GP to demonstrate that they had been authorised in line with legal requirements and national guidance.

Monitoring risks to patients

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice used regular locum GPs from a locum agency to cover if ever the GP was on leave. The practice shared records with us which demonstrated that the appropriate recruitment checks were completed for their locum GPs.

There were some policies in place for the management of health, safety and fire. However, during our inspection we found gaps across a number of areas in assessing, monitoring and mitigating risks to patients.

- Formal risk assessments were not in place to cover risks associated with the premises including health, safety and fire risk.
- Formal risk assessments were not in place to cover risks associated with infection control, such as the control of substances hazardous to health (COSHH) and legionella.
- Staff confirmed that the fire alarm was tested on a weekly basis however records were not kept to support that tests took place. Staff also confirmed that fire drills had not taken place in the practice.

Shortly after our inspection the practice completed a fire risk assessment and organised fire training for practice staff.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents.

- There was a system on the computers in all the treatment rooms which alerted staff to any emergency in the practice.

Inadequate

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Records showed that all staff had received training in basic life support.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. The emergency medicines were in date and records were kept to demonstrate that they were regularly checked and monitored. During our inspection we found that the practice had not assessed the risk in the absence of specific emergency medicine associated with minor surgery and the procedure of fitting specific birth control devices. Shortly after the inspection the practice confirmed that they had ordered the recommended emergency medicines for this procedure.
- The practice did not have a business continuity plan in place to guide staff on how to deal with major incidents, such as a power failure or building damage.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Conversations with members of the clinical team demonstrated that although they were able to access to guidance and standards, such as best practice guidance from the National Institute for Health and Care Excellence, we found that patient's needs were not always assessed in line with relevant and current evidence based guidance and standards. For example, we identified gaps in record keeping to demonstrate that patients had received adequate medication reviews.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results from 2014/15 were 92% of the total number of points available, with 5% exception reporting. Exception reporting is used to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medicine cannot be prescribed due to a contraindication or side-effect.

QOF data showed that diagnosis rates for patients identified with dementia were 100%, with an exception rate of 0%. We also found that, there were only four patients registered with a diagnosis of dementia. The practice had a total of 389 patients aged over 65; this was approximately 12% of the practices population. The data provided by the practice highlighted that one (25%) of these patients had a care plan in place and all four patients had received a medication review in a 12 month period. However, we found that these records lacked sufficient detail and did not demonstrate that the four patients had received an adequate medication review. We reviewed this further during a focussed inspection on 4 April and found that since our initial inspection visit, clinicians had been instructed to use a local dementia care plan template by the lead GP. We saw that the template had been used at the end of March 2016 to document a care plan for a patient who was diagnosed with dementia. This reflected a detailed care plan; however there were still three of the four patients on the dementia register who did not have a care plan in place.

Data provided by the practice highlighted that they had 19 patients on the mental health register. The report also highlighted that four (21%) of these patients had care plans in place and all 19 patients had received a medication review in a 12 month period.

During our inspection visits on 9 March and 4 April 2016 we focused on the practices performance for mental health related indicators, which was 84% compared to the CCG and national average of 93%. We looked in to the data during our inspection and found that out of a sample of four records, the records lacked sufficient detail and did not demonstrate that the patients had received an adequate medication review. For example, a medication review was coded on a patients record who attended the practice in February 2016, the record highlighted that only the patients' blood pressure had been taken. We also found that a care plan was not in place for an elderly patient on the practices mental health register.

The percentage of patients with hypertension having regular blood pressure tests was 100%, with an exception rate of 0%.

Performance for overall diabetes related indicators was 97% compared to the CCG average of 88% the national average of 89%.

The practice had four patients on their palliative care register. However, data provided by the practice highlighted that none of these patients had care plans in place. We reviewed this further during our focussed inspection on 4 April and found that care plans were still not in place.

There were 7 patients on the practices learning disability register. The practice shared a report which highlighted that only one of these patients had a care plan in place that no reviews had taken place within 12 months.

The practice worked with a pharmacist from their Clinical Commissioning Group (CCG) who attended the practice once a week. The pharmacist assisted the practice with medicine audits and monitored their use of antibiotics to ensure they were not overprescribing. National prescribing data showed that the practice was similar to the national average for medicines such as antibiotics and hypnotics.

Requires improvement

Are services effective?

(for example, treatment is effective)

We saw records of a single cycle prescribing audit carried out by the CCG pharmacist, the audit reviewed prescribing across a range of areas including the prescribing of specific medicines used to treat conditions such as angina and high blood pressure, for patients with asthma. The audit identified seven patients at risk for review in July 2015, we looked at two specific records from the at risk criteria during our focussed inspection visit on 4 April and found that although these patients had been seen in the practice since the audit took place, there was no evidence in the records to demonstrate that the required medication reviews had taken place.

During our inspection on 9 March we looked at records of two reviews on diabetes and minor surgery and one clinical audit on antibiotic prescribing. The aim of the antibiotic audit was to undertake a review of patients who had been prescribed antibiotics to review appropriateness and to ensure that prescribing reflected local and national guidelines. The first audit was carried out in January 2015, the audit highlighted that out of 40 cases reviewed, antibiotic prescribing was appropriate in 34 (85%) of the cases and that the recommended prescribing formulary was not adhered to on 6 (15%) of the cases reviewed. As a result of the audit an action plan was produced to remind all practice prescribers to familiarise themselves with formulary indications for common infections. Prescribers were reminded that they could also access antibiotic guidelines through a short cut to the formulary on each computer desktop. We also saw that summary sheets of antibiotic guidelines were produced for each clinical room for ease of use and quick reference. Although the audit document contained a section to repeat the audit in January 2016, we found that this section of the audit record was blank and therefore the audit had not been repeated to complete the audit cycle and therefore did not monitor or review improvements.

Effective staffing

- The practice had an induction programme for newly appointed members of staff that covered role specific training and topics such as safeguarding, infection control, fire safety, health and safety and confidentiality. Staff also made use of e-learning training modules. However, the practice did not have an induction pack for locum clinicians to use when working at the practice.
- We saw records which demonstrated that some staff received ongoing training and support. For example, we saw that the practice nurse had been supported to attend a number of training updates. These included clinical updates on cytology and diabetes. However, some staff member's appraisals were significantly overdue. For example, we saw that an appraisal took place in 2014 for the practice nurse and 2012 for the practice manager and staff confirmed that no further appraisals had been completed since.
- There was some support for the revalidation of doctors and conversations with the practice nurse highlighted that they were also preparing for the upcoming revalidation of nurses (starting in April 2016). The GPs were up to date with their yearly continuing professional development requirements and had been revalidated. 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.

Coordinating patient care and information sharing

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital.

We saw evidence that multi-disciplinary team meetings took place, with representation from a range of health and social care services. We saw that the practices palliative care register was reviewed during the MDT meetings to discuss the care and support needs of patients and their families. Staff explained that patient registers were regularly reviewed during the MDT meetings, including patients on the practices dementia register, patients with a learning disability and patients experiencing poor mental health. Staff we spoke with also said that patients who were at risk of hospital admission were reviewed and discussed during the practices MDT meetings. We saw some evidence of this in the minutes of the most recent MDT meeting however; we found that an MDT meeting had not taken place since January 2016. We discussed this further during our focussed inspection on April 4 and identified that an MDT meeting had not taken place between our inspection visits and that there was the continued risk that some patients with complex needs were had not been reviewed and discussed with the

relevant multi-disciplinary team. Staff explained that an MDT meeting was scheduled for March 2016 and that members could not attend on this occasion, staff advised that patients with complex needs were reviewed by the practice nurse and pharmacist during this period. We also received mixed information with regards to the dissemination of minutes from MDT meetings, one member of staff explained that minutes were disseminated to any of the practices GPs who were unable to attend the MDT meetings however another staff member we spoke with said that minutes are recorded but not shared in the practice; to ensure that all clinicians were able to view discussions, actions and learning points specific to any patients with complex needs who were discussed as part of the MDT meetings.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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, where appropriate, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Supporting patients to live healthier lives

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74 and for people aged over 75. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Patients who may be in need of extra support were identified and supported by the practice. Patients were also signposted to relevant services to provide additional support.

- The practice nurse operated an effective failsafe system for ensuring that test results had been received for every sample sent by the practice. The practice's uptake for the cervical screening programme was 83%, compared to the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.
- The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. National cancer intelligence network data from March 2015 highlighted that breast cancer screening rates for 50 to 70 year olds was 76% compared to the CCG and national averages of 72%. Bowel cancer screening rates for 60 to 69 year olds was 61% compared to the CCG and national averages of 58%.
- Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for under two year olds ranged from 80% to 100% compared to the CCG averages which ranged from 40% to 100%. Immunisation rates for five year olds ranged from 89% to 97% compared to the CCG average of 93% to 98%.
- Flu vaccinations for those patients in the at risk groups was 51%, compared to the national average of 52%. The latest flu vaccination rates for the over 65s was 69%, compared to the national average of 73%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed a friendly atmosphere throughout the practice during our inspection. We noticed that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

- Curtains and screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff advised that a private area was always offered to patients who wanted to discuss sensitive issues or appeared distressed.

We spoke with four patients on the day of our inspection. They also told us they were satisfied with the care provided by the practice; patients said their dignity and privacy was respected and staff were described as friendly, helpful and caring.

The results from the national GP patient survey published in January 2016 showed mixed responses with regards to treating patients with compassion, dignity and respect. For example:

- 88% said the GP was good at listening to them compared to the CCG average and national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average and national average of 89%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 84% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 91% patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and national averages of 87%.
- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average and national averages of 85%.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. However, results from the national GP patient survey did not reflect the feedback we received during our inspection with regards to questions about patient involvement in planning and making decisions about their care and treatment:

- 83% said the last GP they saw was good at explaining tests and treatments compared to the CCG national average of 86%.
- 77% said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%

Patient and carer support to cope emotionally with care and treatment

- Notices in the patient waiting room told patients how to access a number of support groups and organisations.
- The practice's computer system alerted GPs if a patient was also a carer. Although supportive information was displayed in the waiting room there was no information available to specifically support carers.
- Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.
- The practice also provided information and supported patients by referring them to counselling services and further support organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example:

- There were longer appointments available at flexible times for people with a learning disability, for carers and for patients experiencing poor mental health. Urgent access appointments were available for children and those with serious medical conditions.
- Clinical staff carried out home visits for older patients and patients who would benefit from these.
- Appointments could be made in the practice, over the phone and online. There was a text messaging appointment reminder service available and the practice also used an electronic prescription service.
- The practice offered extended hours from 6:30pm to 7:30pm on Mondays, Tuesdays and Wednesdays for those who could not attend the practice during core hours.
- The practice offered a range of clinical services which included care for long term conditions such as diabetes, a range of health promotion and the GPs also offered minor surgery to registered patients and for patients who were locally referred from their own GP.
- There were disabled facilities and translation services available. The practice did not have a hearing loop, staff we spoke with said that they did not have any deaf patients and any patients with hearing impairments.

Access to the service

The practice was open between 8am and 6pm Monday to Friday. Appointments ran between 9am 12pm and then from 4pm to 6:30pm. The GP was on call each morning from 8am to 9am and during the afternoons when appointments were closed. The practice offered extended hours from 6:30pm to 7pm on Tuesdays and from 6:30pm to 7:30pm on Thursdays for those who could not attend the practice during core hours. Pre-bookable appointments could be booked up to six weeks in advance and urgent appointments were also available for people that needed them.

Results from the national GP patient survey published in January 2016 showed mixed results with regards to accessing the service:

- 91% patients said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 73%.
- 87% patients described their experience of making an appointment as good compared to the CCG average of 70% and national average of 73%.
- 84% of patients were satisfied with the practice's opening hours compared to the CCG and national average of 75%.

The practice had not reviewed their results from the national GP patient survey and the practice did not have an action plan in place to demonstrate how improvements to the service could be made for areas such as appointment waiting times. Results from the national GP patient survey highlighted that the practice was below the local and national averages for appointment waiting times:

- 49% of patients usually waited 15 minutes or less after their appointment time to be seen compared with the CCG average of 64% and a national average of 65%.
- 50% of patients felt they did not normally have to wait too long to be seen compared with the CCG average of 59% and national average of 58%.

The practice had changed their appointment system from a walk in and wait system to bookable appointments in June 2015. Discussions with the practice manager highlighted that this may have impacted on the practices survey results. Patients we spoke with on the day of our inspection commented that appointments usually ran to time.

Listening and learning from concerns and complaints

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice website and leaflet guided patients to contact the practice manager to discuss complaints.
- The practice shared records of the three complaints they had received in the last 12 months. Records demonstrated that complaints were satisfactorily handled and dealt with openness and transparency.

Good

Are services responsive to people's needs?

(for example, to feedback?)

However, complaints were not factored in to the minutes of practice meetings to demonstrate that learning from complaints was shared with the practice team.

- Patients we spoke with on the day of our inspection were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.
- The practice had several negative comments on their NHS Choices web page. We noticed that the practice had not responded to their comments since June 2014 to show patients that they were listening to and acting on their 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 practices vision was to **provide the very best service to patients, in a traditional practice.**

We spoke with eight members of staff during our inspection. Although staff spoke positively about working at the practice, not all staff said that they felt supported. Some staff commented that they were a friendly team and that they were proud of the rapport they had built with their patients.

Governance arrangements

The practice had some policies and protocols in place which were accessible to staff. The policies were practice specific and had been reviewed. However, overall we found that governance arrangements were not robust, for example:

- We identified a number of gaps in the arrangements for identifying, recording and managing risks. The practice had not assessed risk associated with premises and risk associated with infection control. Additionally, the practice had not assessed the risk in the absence of disclosure and barring checks (DBS checks) for members of the practice team who provided a chaperone service.
- Records were not in place to provide assurance that appropriate recruitment checks had been completed for both non-clinical and clinical members of the practice team.
- Patient outcomes were hard to identify as little reference was made to quality improvement. Significant event records and the minutes of meetings contained limited information and did not demonstrate a culture of learning. The practice did not review themes or trends from significant events and complaints.
- The practice did not operate an effective programme of clinical audits.
- The practice had not developed a formal plan to work on the areas identified for improvement from the national GP patient survey. The practice manager had not reviewed the results as they were unfamiliar with the survey. Additionally, no in-house survey had been conducted and therefore the practice did not have an action plan in place to demonstrate how improvements to the service could be made.

Leadership, openness and transparency

The lead GP and the practice manager formed the management team at the practice. Conversations with staff demonstrated that they were aware of the practice's open door policy and staff said they were confident in raising concerns and suggesting improvements openly with the management team.

Staff explained that there was a regular programme of staff meetings where meetings took place every two to three months. Staff we spoke with said that they communicated as a close team on a day to day basis and staff highlighted that they hadn't had a formal practice meeting for a few months. We saw that hand written minutes reflected meetings held during May and June 2015. The minutes of the meetings highlighted how changes to processes were shared with staff although agendas were not prepared to include key items for discussion, such as complaints and significant events. The practice nurse explained that informal nurse meetings took place on a weekly basis between the two practice nurses and the practice manager was able to regularly engage with other practice managers by regular attendance at the Dudley practice manager alliance (DPMA) meetings.

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

The practice's patient participation group (PPG) consisted of several members. We spoke with a member of the PPG on the day of our inspection. The PPG member explained that the PPG met every three months at the practice. The PPG member outlined some of the improvements implemented in the practice which were supported by the PPG. For example, improving access to the practice premises by installing automatic doors and hand rails for people with mobility difficulties.

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 There was a lack of systems and processes in place to provide assurance that the premises and the equipment used by the service were safe for service users and staff. Formal risk assessments were not in place to monitor and mitigate risks associated with health and safety of the premises and infection control, such as legionella and the control of substances hazardous to health (COSHH). The arrangements for managing medicines, including emergency drugs and vaccinations, were not robust to ensure that patients were kept safe. Records for vaccination fridges did not reflect guidance by Public Health England with regards to monitoring temperatures to ensure that the cold chain was adequately maintained. We saw that some patient group directives (PGDs) had not been signed by a GP. Prescription pads were used for home visits and these were stored securely, however the practice did not have a system in place to track and monitor their use. There was no formal emergency or contingency plan in place to support the practice in the event of a major incident.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Medication reviews were not always part of patient's care and treatment assessments as required. The provider could not demonstrate compliance with relevant patient safety alerts, recalls and rapid response reports, such as those issued from the Medicines and Healthcare product Regulatory Agency (MHRA). Care plans were not always completed and the provider could not demonstrate that regular reviews took place in line with patient's medication changes and needs.

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 practice did not actively seek and respond to the views of service users and staff, the provider could not demonstrate that they had reviewed, analysed or put plans in to place to improve in relation to the national GP patient survey and no internal surveys had been conducted in practice. Appraisals were overdue for members of staff. Records relating to people employed by the service were not in place for all staff members. We found that records were limited and lacked sufficient information. Therefore the provider was unable to demonstrate compliance with the requirements under regulations 4 to 7 and regulation 19 (part 3) of the Health and Social Care Act 2008 (Regulated Activities). Effective systems and processes were not in place to enable the provider to identify and assess risks to health, safety and welfare of people who use the service, such as risk assessments in the absence of disclosure and

This section is primarily information for the provider

Enforcement actions

barring (DBS) checks for staff; including staff who chaperone. We identified gaps in record keeping for infection control, such as infection control audit outcomes and records to reflect the cleaning of specific medical equipment and clinical rooms.

The practice could not demonstrate how they effectively evaluated and improved the quality and safety of services. Patient outcomes were hard to identify as little or no reference was made to clinical audits.