Dr Taj Khattak

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?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive to people's needs?	**Requires improvement**
Are services well-led?	**Inadequate**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Taj Khattak Surgery on 18 May 2016. Overall the practice is rated as inadequate.

Dr Taj Khattak surgery has been through a period of change due to the departure of their practice nurse and practice manager. Two weeks prior to the inspection the practice recruited a locum nurse, locum practice manager and a permanent manager. During the inspection the practice recruited a GP partner and is now receiving support from Walsall Clinical Commissioning Group.

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, the systems in place to review and investigate incidents were not thorough enough. Patients did not always receive an apology.
- The practice did not have a system for shared learning, they did not hold regular practice or clinical meetings and they were not attending external meetings with other healthcare professionals
- Risks to patients were not always assessed and well managed, for example there were no care plans for vulnerable people at risk of acute admission and the practice did not establish a clear system for receiving medicines and healthcare products regulatory (MHRA) alerts. There were gaps in the practice recruitment checks.
- Although some audits had been carried out, we saw no evidence that audits were driving improvements to patient outcomes.
- The majority of patients said they were treated with compassion, dignity and respect. However, data from the GP patient survey identified that, of those responding not all felt cared for, supported and listened to.
- There was limited information available about services; the practice did not have a practice leaflet or a web site for online access.

Summary of findings

- Although the practice had a suggestion box for patients to provide feedback they did not provide information on how to make a complaint.

- The practice had a number of recently implemented policies and procedures to govern activity; however they were not fully embedded.

The areas where the provider must make improvements are:

- Ensure they are signed up to receive medicines and healthcare products regulatory (MHRA) alerts and establish a system to manage and disseminate these alerts.
- Actively seek and act on feedback on the services provided for the purposes of continually evaluating and improving service delivery.
- Implement a system for shared learning through internal and external meetings with other health care professionals.

- The practice must do all that is reasonably practicable to mitigate risks, for example follow good practice guidance and adopt control measures to ensure risks such as legionella is reduced and fire risk assessments are in place. The practice must also carry out and record fire drills.
  - Ensure policies and procedures are maintained, within date and embedded into the practice. Ensure an effective audit system is in place to drive service improvement
  - Ensure staff receive appropriate support such as training, professional development and appraisals as is necessary to enable them to carry out the duties they are employed to perform. For example chaperoning, safeguarding and infection control training.
  - Ensure systems and processes are in place and established to ensure safeguarding concerns are acted on immediately.
  - Create clear care and/or treatment plans where appropriate, which are available to all staff involved in providing the care.
  - Ensure recruitment arrangements include all necessary employment checks for all staff.
  - Ensure systems are in place to monitor and renew clinical staff's medical indemnity.
  - Ensure equipment to deal with medical emergencies is fit for purpose.
  - Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. The practice should ensure information on how to make a complaint is available for patients.
  - Have a completed comprehensive business continuity.

In addition the provider should:

- Consider how they ensure patients have the necessary information available to them in the absence of a practice website and patient leaflet.
- Explore ways how they can proactively identify and support carers.

- In the absence of a Patient Participation Group consider how to gather the views of people who use their service and support actions needed to respond to feedback.

I am placing this service in special measures. Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, we place it into special measures.

Services placed in special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as 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 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 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.

Special measures will give people who use the service the reassurance that the care they get should improve. We are currently carrying out enforcement actions against the provider and will report on the outcomes at a later date.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

The practice is rated as inadequate for providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Patients did not always receive a verbal or a written apology.
- Although some 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.
- The practice had a written safeguarding policy and a safeguarding lead. Staff safeguarding knowledge varied and we saw that not all staff had received safeguarding training relevant to their role, this included the safeguarding lead.
- There were gaps in the recruitment process, for example we checked staff files and there was no evidence of a role specific induction; employment history, proof of identification and references were missing from some staff files.
- We saw that emergency medicines were easily accessible and were in date. The GP did not carry out a risk assessment to mitigate risks associated with not carrying medication in the GP bag during home visits.
- The practice did not have a comprehensive business continuity plan in place however we were told that the practice had an immediate response plan for incidents such as a power, gas or phone failure.
- Although the practice had equipment to deal with medical emergencies when checked we saw that there were parts missing for example there were no leads or pads for the defibrillator.

Are services effective?

Inadequate 

The practice is rated as inadequate for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Although the practice accessed current evidence based guidance there were no systems in place to keep all clinical staff up to date.

Summary of findings

- Little reference was made to audits or quality improvement and there was limited evidence that the practice was comparing its performance to others; either locally or nationally. There was little evidence that audit was driving improvement in patient outcomes.
- Not all staff received appropriate training to enable them to deliver effective care and treatment. For example staff we spoke with had not received infection control, safeguarding, chaperoning and information governance training.
- The practice were not carrying out appraisal, however we saw that they had developed training needs analysis for some staff members.
- Multidisciplinary working was not always taking place and record keeping was limited or absent. For example the practice were not attending or contributing to meetings for their palliative care patients.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. For example the practice was below average for its satisfaction scores on consultations with the GP however comparable for consultations with the nurse.
- Patients we spoke to on the day of the inspection said they felt involved in decision making about the care and treatment they received. Patients also said they felt listened to, supported and had sufficient time during consultations to make an informed decision.
- There was insufficient information available to help patients understand the services available to them.
- Although the practice had identified carers, when asked we were told that the practice were not offering support for carers. We saw that there was no information available to direct carers to various avenues of support.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as required improvement for providing responsive services.

- Practice staff reviewed the needs of its local population and there was evidence of engagement with the Clinical

Summary of findings

Commissioning Group to secure improvements to services. For example the CCG pharmacist attended that practice four to eight hours per week to support the practice with medicine management.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a designated person responsible for handling complaints Information was not available for patients about how to complain. We were told that that practice had responded to ad hoc patient feedback however these were not being documented in order to identify themes, trends and areas for improvement.

Are services well-led?

Inadequate

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

- Although the practice had an objective to increase its staff, the practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- There was no clear leadership structure however staff we spoke with felt supported by the provider.
- The practice had some policies and procedures to govern activity, but these were created two weeks prior to the inspection therefore had not become fully implemented.
- The practice did not hold governance meetings and there were no evidence of where issues, such as risk management, complaints and incidents were being discussed.
- The practice had not proactively sought feedback from staff or patients. The practice did not have a patient participation group; however there were plans in place to re-engage with the PPG.
- Staff told us they had not received regular performance reviews and we did not see documentation of any clear objectives for staff.

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 the care of older people. This is because the concerns identified in relation to how safe, effective, caring, responsive and well-led the practice was impacted on all population groups.

- Care and treatment of older people did not always reflect current evidence-based practice, and some older people did not have care plans where necessary.
- Structured annual health checks for patients aged 75 plus were not always being carried out, for example only 2% of patients aged 75 plus had received health checks.
- The practice was not involved in multidisciplinary discussions, when asked the practice were unable to demonstrate effective joint care to meet the needs of older people.
- Home visits and longer appointments were available where needed; the practice also offered same day telephone consultations where appropriate.
- There was no information available which sign posted patients to support services or volunteer services such as local community groups or charities such as age UK.
- Although the practice were providing follow up consultations following discharge form hospital there were no completed care plans which reflected any additional needs.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. This is because the concerns identified in relation to how safe, effective, caring, responsive and well-led the practice was impacted on all population groups.

- Overall performance for diabetes related indicators was comparable to the national average. For example 95% compared to the national average of 89%.

Summary of findings

- Longer appointments and home visits were available when needed. Patients with long term conditions had a named GP and there were systems in place for an annual recall to check that their health and care needs were being met, however patients did not have a personalised care plan.
- Although the practice held a list of patients with long term conditions (LTC) and there were a nominated lead for palliative care, the practice were not holding or attending multidisciplinary meetings to discuss and review care needs.
- There were systems in place via the CCG pharmacist to review patient's medication.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. This is because the concerns identified in relation to how safe, effective, caring, responsive and well-led the practice was impacted on all population groups.

- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 89% to 100% and five year olds 100% for all vaccinations.
- Appointments were available outside of school hours. The premises were suitable for families, children and young people.
- The practice's uptake for the cervical screening programme was 90%, which was above the CCG and national average of 81%.
- Although the practice held a list of patients with safeguarding concerns when asked we were told that the lead were not attending multi-disciplinary meetings. We saw that the safeguarding lead had not received relevant training to enable them to carry out this role.
- Confidentiality and privacy for children and young people was available, there was a poster in reception to make patients aware of confidentiality and patients were being offered the opportunity to be seen without a parent or carer where appropriate.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). This is because the concerns identified in relation to how safe, effective, caring, responsive and well-led the practice was impacted on all population groups.

- The age profile of patients at the practice was above average for those aged 40 to 75; however the practice had a low uptake rate for NHS health checks for this population group. For example 4% had received a NHS health check, we were told that this were due to the absence of a practice nurse.
- The practice offered extended opening hours for appointments on Mondays, there were processes in place which allowed patients to order repeat prescriptions via the telephone.
- Health promotion advice was being offered during consultations however there were limited accessible health promotion material available throughout the practice.
- The practice offered support to enable patients to return to work, for example patients who were likely to be off work for four weeks were offered the option to be referred to the government fit for work scheme.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. This is because the concerns identified in relation to how safe, effective, caring, responsive and well-led the practice was impacted on all population groups.

- Although the practice held a register of patients identified with a learning disability (LD) there were limited evidence of annual health checks being carried out. There was no evidence of completed personal care plans.
- There were no systems in place for sharing information about people at risk of abuse with other services.
- The practice was not proactive in engaging with families and carers of patients with learning disabilities. We were told that there was no support provided for carers.

Summary of findings

- Not all staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children.
- Not all staff were clear of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- We were told that the practice did not have any registered patients who were living in vulnerable circumstances; there were no registration processes in place for this patient group. For example when asked we were not provided with a policy of process for registering homeless patients.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). This is because the concerns identified in relation to how safe, effective, caring, responsive and well-led the practice was impacted on all population groups.

- 71% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is below the CCG average of 79% and below national average of 77%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was below CCG and national average. For example 71% compared to CCG and national average of 84%.
- The practice had not worked with multi-disciplinary teams in the case management of people experiencing poor mental health. Although the practice held a register of these patients there were limited evidence of annual health checks being carried out and no evidence of completed personal care plans.
- Staff we spoke to had not received training on how to care for people with mental health needs and there were no dementia training available. However clinical staff we spoke to demonstrated awareness of the Mental Capacity Act and process for gaining consent.
- The practice were not attending or holding meetings with the community nursing team to discuss patient's needs.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages for some areas however were less favourable regarding questions relating to the GP. Two hundred and ninety-one survey forms were distributed and 109 were returned. This represented a 37% response rate, compared to the national average of 38%.

- 89% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 95% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 85% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 69% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 38 comment cards which were mainly positive about the standard of care received. Patients felt satisfied with the level of care provided, the comment cards highlighted the professionalism and politeness of staff. Patients also felt that staff were supportive, approachable, caring and all staff do their best to help. Patients felt listened to by the GP and felt that the GP understood their worries.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Patients we spoke with had been registered with the surgery for a number of years and found it very convenient.Patients also felt their privacy and dignity were always respected.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure they are signed up to receive medicines and healthcare products regulatory (MHRA) alerts and establish a system to manage and disseminate these alerts.
- Actively seek and act on feedback on the services provided for the purposes of continually evaluating and improving service delivery.
- Implement a system for shared learning through internal and external meetings with other health care professionals.
- The practice must do all that is reasonably practicable to mitigate risks, for example follow good practice guidance and adopt control measures to ensure risks such as legionella is reduced and fire risk assessments are in place. The practice must also carry out and record fire drills.
- Ensure policies and procedures are maintained, within date and embedded into the practice. Ensure an effective audit system is in place to drive service improvement
- Ensure staff receive appropriate support such as training, professional development and appraisals as is necessary to enable them to carry out the duties they are employed to perform. For example chaperoning, safeguarding and infection control training.
- Ensure systems and processes are in place and established to ensure safeguarding concerns are acted on immediately.

Summary of findings

- Create clear care and/or treatment plans where appropriate, which are available to all staff involved in providing the care.
- Ensure recruitment arrangements include all necessary employment checks for all staff.

- Ensure systems are in place to monitor and renew clinical staff's medical indemnity.
- Ensure equipment to deal with medical emergencies is fit for purpose.
- Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. The practice should ensure information on how to make a complaint is available for patients.
- Have a completed comprehensive business continuity.

Action the service SHOULD take to improve

In addition the provider should:

- Consider how they ensure patients have the necessary information available to them in the absence of a practice website and patient leaflet.

- Explore ways how they can proactively identify and support carers.
- In the absence of a Patient Participation Group consider how to gather the views of people who use their service and support actions needed to respond to feedback.

Dr Taj Khattak

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC), Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector and a practice manager specialist adviser.

Background to Dr Taj Khattak

Dr Khattak Surgery is located in Walsall, West Midlands situated in a purpose built single level building, providing NHS services to the local community. Based on data available from Public Health England, the levels of deprivation (Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial) in the area served by Dr Khattak Surgery are comparable to the national average, ranked at five out of 10, with 10 being the least deprived.

The practice serves a higher than average population of patients aged between 40 to 85 plus. The patient list size is just below 2000. Dr Taj Khattak surgery is run by one GP and the service delivery is supported by a locum practice nurse, one locum practice manager, one employed practice manager and an administration team. Services to patients are provided under a General Medical Services (GMS) contract with the Clinical Commissioning Group (CCG). GMS is a contract between general practices and the CCG for delivering primary care services to local communities.

The surgery 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. These directed enhanced services include, childhood vaccination and immunisation, extended hours access, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, minor surgery, rotavirus and shingles immunisation and unplanned admissions. The surgery is registered to deliver treatment of disease, disorder or injury; maternity and midwifery services; diagnostic and screening procedures.

The practice is open between 8:30am to 6pm. GP consulting hours are 9am to 11:30am and 5:30pm to 6:30pm on Monday, 9:30am to 11:30am and 4:30pm to 5:30pm on Tuesday, Wednesday and Friday. Thursday surgery times are from 9:30am to 11:30am. Extended consulting hours are offered on Monday between 6:30pm and 7:30pm. The practice has opted out of providing cover to patients in their out of hours period. During this time services are provided by Waldoc from 8:00am to 8:30am and 1:00pm to 3:30pm; Primecare provides services from 6:30pm to 8:00am.

The practice was previously inspected by CQC under the old methodology on 17 February 2014 and was found that Dr Taj Khattak was in breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 for not ensuring staff were always appropriately trained and supervised in delivering care and treatment to patients who used the service. Dr Taj Khattak was also in breach or Regulation 10(1)(a) of the Health and Social Care Act 2008 for not having an effective system in place to regularly assess and monitor the quality of services that patients received.

CQC carried out a responsive follow up inspection on 11 June 2014 to check whether actions had been taken to meet the requirements identified in February 2014. CQC found that Dr Taj Khattak had met the standards to enable him to support workers, assess and monitor the quality of service provision.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 May 2016. During our visit we:

- Spoke with a range of staff for example the practice manager, locum practice manager, receptionist and the community pharmacist. We also spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

Although we saw that significant events were discussed in the GPs appraisal there was no internal system in place for reporting, recording and sharing learning from these significant events at the practice.

- Staff we spoke to told us they would either inform the practice manager or GP of any incidents. We saw that the GP had discussed two significant events during their appraisal, however when asked for examples of a completed internal recording form or a system for capturing the information we were provided with an incomplete incident and accident log book. When asked the practice were unable to provide evidence of an internal system to record, action and share learning from significant events. For example we were told about two significant events which had occurred in the past 12 months; staff we spoke with told us about a new procedure for the management of prescriptions however there were no documentation to evidence where learning had been discussed, who was responsible for the actions and whether patients had been informed. When asked staff we spoke with told us they we were not carrying out an analysis of the significant events; therefore there was no evidence of shared learning or meetings to discuss significant events.
- Staff were unable to provide an incident recording form which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) we were told that the practice had recently developed a new policy for incidents and significant events that they were in the process of implementing.

We asked staff to provide us with evidence where they were reviewing safety records and, patient safety alerts and minutes of meetings where these were discussed. We were not provided with evidence that actions were taken to improve safety in the practice. Staff we spoke to told us that the practice manager and community pharmacist were receiving and acting on to medical alerts. However when asked to provide examples the surgery were unable to provide a clear system for cascading or acting on actions to improve safety in the practice. When we asked for examples of meetings where the practice were discussing actions to improve patient safety we were told that the surgery were not conducting internal meetings.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, for example:

- The practice had a written safeguarding policy which was accessible to all staff reflecting relevant legislation and local requirements to safeguard children and vulnerable adults from abuse. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP was the lead member of staff for safeguarding however when asked we were told that the GP was not attending safeguarding meetings and had not provided reports for other agencies. We asked for examples of reporting safeguarding concerns and whether GP had access to safeguarding policy and procedures, we were told that there were no patients on the safeguarding register and the GP was not accessing practice policy and procedures. Staff we spoke with varied in their ability to demonstrate that they understood their responsibilities and what constituted a safeguarding concern. For example some staff were able to clearly demonstrate their role in safeguarding and who to speak to, however other staff members were unable clearly explain their role in safeguarding vulnerable children or adults. Staff we spoke with told us that they had not received training on safeguarding children and vulnerable adults relevant to their role. The GP had not been trained to child protection or child safeguarding level 3. When asked we were not provided with evidence that the nurse had completed safeguarding training.
- A notice in the waiting room advised patients that chaperones were available if required. Staff we spoke with who acted as chaperones told us they received a discussion around what to do when acting as a chaperone however had not received formal training for the role. When asked staff were unable to explain the correct procedure when acting as a chaperone. We saw that staff who acted as a chaperone had received a Disclosure and Barring Service (DBS) check. (DBS checks

identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The GP was the infection control lead however when asked we were not provided with evidence that the GP liaised with the local infection prevention teams to keep up to date with best practice. The surgery recently developed an infection control protocol, however when asked we were told that the infection control lead and staff had not received any infection control training. We saw that there were infection control audits undertaken however they were not being carried out annual for example we saw that an external audit had been carried out in 2013 and a second in-house audit carried out 13 May 2016. We saw evidence that actions were taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We saw that the vaccination fridges were well ventilated and secure. Vaccinations were stored within the recommended temperatures and temperatures were logged in line with national guidance. The community pharmacist who told us they attend the surgery every week for four to eight hours. We were told that the CCG pharmacist carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms, pads and other stationary were securely stored and there were systems in place to monitor their use.
- We reviewed seven personnel files and found gaps in recruitment checks undertaken prior to employment. For example, we saw proof of identification for three out of seven files we checked and references for two out of seven, evidence of registration with the appropriate professional body were not located in the files. We saw that appropriate checks through the Disclosure and Barring Service were carried out on five out of seven staff members. Following the inspection we were advised that registration with the appropriate professional body was in place for all clinical staff.

Monitoring risks to patients

Not all risks to patients were assessed and managed, for example:

- There was a health and safety policy available. Staff we spoke with told us that the practice introduced their fire safety policies and procedures two weeks prior to the inspection, when asked we were not provided with a fire risk assessments and we were told that they were not carrying out regular fire drills. We checked some pieces of electrical equipment to ensure the equipment was safe to use, we saw that appliances had in date test labels carried out by an external company. We also saw that clinical equipment was tested to ensure they were working properly. Although the practice had a control of substances hazardous to health risk assessment for their cleaning fluids and a health and safety risk assessment in place when asked we were told that they were no infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) risk assessment in place. Staff told us they were no processes in place for testing the water.
- We were told that arrangements were in place for ensuring the surgery had the right number of staff and mix of staff needed to meet patients' needs. For example we were told that the practice manager provided cover to ensure enough staff were on duty. We were told that the surgery were not using locums however there were arrangements with local GP colleague's to provider GP cover. We were told that the surgery had not used GP cover in the past year however they were using a locum nurse one day per week until they recruited a full time practice nurse.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Inadequate

Are services safe?

- Staff we spoke to had received annual basic life support training.
- The practice had a defibrillator available on the premises however when checked there were no leads or pads. There was oxygen on site with adult and children's masks however tubing was not attached. We saw that a first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. However when asked we were told that the GP were not storing medication in their home visit bag and we were not provided with a risk assessment to mitigate risks.
- We were told that the surgery did not have a comprehensive business continuity plan in place however they had an immediate response plan for major incidents such as power, gas or phone failure. Staff we spoke with told us they would contact the CCG in the event of a major incident.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice were not always assessing patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- We saw that the GP had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs however there were no evidence of systems to keep other clinical staff up to date.
- There were some evidence that the practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. For example the CCG pharmacist told us that they were attending the surgery between four to eight hours per week to monitor prescribing. We saw that the CCG Pharmacist conducted an audit on antibiotic prescribing in response to the GPs higher than CCGs expected average for prescribing antibiotics. As a result we saw that changes were implemented.
- Although the CCG pharmacist were conducting prescribing audits, when asked we were not provided with any evidence of practice lead checks, audits or risk assessments. We were told that the practice did not have a yearly audit plan of clinical areas they were planning to review.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets however exception reporting for some domains was higher than CCG and national average (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2014/15 showed:

- Performance for diabetes related indicators was comparable to the national average. For example 95% compared to the national average of 89%.
- Performance for mental health related indicators was above the national average. For example 99% compared to the national average of 93%. Exception reporting for patients experiencing depression was 75%, compared to CCG average of 23% and national average of 26%.

  There was no evidence of any internally driven quality improvement including clinical audit however.
- There had been two clinical audits completed by the CCG pharmacist in the last two years, both of these were completed audits where the improvements made were implemented and monitored.
- We spoke to the practice GP and were told that there were no practice lead audits completed and we were not provided with a practice audit plan for the year.
- Staff we spoke with told us that the practice were not participating in local audits, national benchmarking, accreditation, attending peer review or involved in research.

Effective staffing

Not all staff we spoke to had the skills, knowledge and experience to deliver effective care and treatment.

- We checked the files of recently recruited staff members and there were no evidence of an induction programme for all newly appointed staff, however we were told this had recently been developed and the practice were in the process of implementing. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice identified the training needs of some staff members. For example, we were provided with a training needs analysis for receptionists which identified training gaps, however we were not provided with evidence for the clinical staff. We saw that the practice

Inadequate

Are services effective?

(for example, treatment is effective)

manager had been attempting to secure training for the receptionists. Following the inspection we were told that online training for staff was in place however staff had not yet completed any of the online courses.

- When asked the practice were unable to provide evidence of staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- We were told that there were no staff appraisals carried out in the last 12 months.

During the inspection we were told that the practice went through a period of a lack of suitable staffing to support the effective functioning of the practice. For example:

- We were told that the receptionist who also acted as the practice manager retired, the practice recruited a second manager who left in 2015, and therefore we saw that the practice had no management in place for 10 months prior to the inspection.
- When asked we were told that the practice had not developed a contingency plan to ensure suitable staff were deployed to manage the functioning of the practice.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. For example:

- We saw a system in place for managing pathology results and saw that they were being actioned the same day and medical records were kept up to date. However we did not see evidence of any completed care plans for vulnerable people at risk of acute admission, patients with long term conditions, there were no risk assessments in place for these patients. There were no care plans for palliative care patients. When asked we were told that the practice as not completing care plan templates however there were plans to start completing these.
- The practice shared relevant information with secondary care in a timely way, for example when patients were admitted or discharged from hospital. We saw evidence where the practice were sharing information with secondary care and following up hospital discharges.

There were some evidence of where staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs. For example following discharged from hospital and when patients moved between services such out of hour's services. We were told that the GP communicated with the palliative care nurse however we were told that they were not attending multidisciplinary meetings to complete, review or update care plans for patients with complex needs.

Consent to care and treatment

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

- Staff we spoke with 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 we spoke with 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 told us they were able to assess the patient's capacity and, recorded the outcome of the assessment.
- We saw that the process for seeking consent was monitored through patient records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- The practice flagged and kept a list of patients with learning disability, dementia, mental health and long term conditions. We were told that the GP communicated with the community nurse for patients receiving end of life care, however when asked the practice were unable to provide evidence of where the GP attended formal meetings or discussions.

Inadequate

Are services effective?

(for example, treatment is effective)

- We saw that the practice identified those who were carers and those requiring advice on their diet however we were not provided with any evidence of support being offered. Staff told us that patients were signposted to smoking cessation services.

The practice's uptake for the cervical screening programme was 90%, which was above the CCG and average of 81%. We were told that the practice were offering telephone reminders for patients who did not attend for their cervical screening test. The practice encouraged uptake of the screening programme by using information in different languages and for those with a learning disability. However we saw that the option of a female sample taker was limited due to the practice only having access to a practice nurse one day per week. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example 78% of females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) compared to CCG and national average of 72%. The practice uptake of persons aged 60-69, screed for bowel cancer within 6 months of invitation (uptake %) was 63% compared to CCG average of 50% and national average of 55%.

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 89% to 100% and five year olds 100% for all vaccinations.

We were told that patients had access to appropriate health assessments and checks one day per week from the locum practice nurse. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Data provided by the practice identified that 4% of patients aged between 40 to 75 had received a health check. When asked we were told that this were due to the practice not having a practice nurse for some time.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

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

All of the 38 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

- 69% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 79% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 73% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 84%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 96% of patients said they found the receptionists at the practice helpful compared to the CCG and national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 75% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 89%.
- 68% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff we spoke with told us that translation services were available for patients who did not have English as a first language and we were told that staff spoke a number of different languages. However we did not see notices in the reception areas informing patients this service was available.
- There was no hearing loop however staff we spoke to told us that they were in the process of purchasing one.

Patient and carer support to cope emotionally with care and treatment

There were limited patient information leaflets and notices available in the patient waiting area which told patients how to access support groups and organisations. The practice did not have a website.

Requires improvement

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 18 patients as carers (1% of the practice list). There was no evidence of proactive support being offered to carers, for example staff we spoke with told us that support was only offered upon the request of patients or their carers. There was no written information available to direct carers to the various avenues of support available to them.

When asked about support for patients who suffered bereavement, we were not provided with an information regarding support offered. There was no information in the reception area signposting patients to support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There were some evidence that the practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG).

For example the practice were providing the following:

- Late clinic on a Monday evening from 6:30pm until 7.30pm for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- There was limited access to a practice nurse, for example nurse clinics were only accessible one day per week.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were disabled facilities, a translation services available however there was no hearing loop.

Access to the service

The practice was open between 8:30am and 6pm Monday to Friday. Appointments were from 9:00am to 11:30am and 5:30pm to 6:30pm on Monday, from 9:30am to 11:30am and 4:30pm and 5:30pm on Tuesday, Wednesday and Friday, from 9:30am to 11:30am on Thursday. Extended hours appointments were offered at the following times on Monday from 6:30pm to 7:30pm. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

There is parking for cyclists and patients who display a disabled blue badge.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 80% of patients were satisfied with the practice's opening hours compared to the national average of 75%.
- 89% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

The practice had a system in place to assess:

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

Staff we spoke to told us that all home visit requests were sent to the GP, we were told that the GP called patients to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

There were gaps in the practice system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- However we saw that there were no information available in the reception area to help patients understand the complaints system and the practice did not have a practice leaflet.

We looked at one complaint which the practice received in the last 12 months and found the complaint was handled and dealt with in a timely way. There was no robust system for recording verbal complaints. When asked we were told that there were no evidence of where lessons were learnt from individual concerns and complaints and no analysis of trends and action taken as a result to improve the quality of care.

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

We were told that the practice had an objective to recruit a new GP partner to support the deliver high quality care and promote good outcomes for patients. Staff we spoke to were aware of this objective

- When asked we were not provided with a strategy and supporting business plans which reflected the vision and values.
- Staff we spoke with were unable to demonstrate a clear understanding of the practice mission statement and values.

Governance arrangements

We were told that the practice had been through a period of no leadership, with key staff members leaving the practice. There had been no contingency plan in place. This had resulted in the lack of an overarching governance framework which supported the delivery of good quality care. We saw that the recruitment of a practice manager resulted in some structures and procedures being implemented. For example:

- Although were not provided with a staffing structure, staff we spoke to were aware of their own roles and responsibilities.
- Practice specific policies were being developed and we were told that the practice were in the process of implementing new policies and were making them available to all staff.
- When asked we were not provided with a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- We were not provided with any arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We did not see evidence of a robust system to monitor medical indemnity. For example although the GP provided a copy of the medical indemnity we saw that the locum nurse indemnity had expired. Following the inspection the practice made us aware that the practice nurse did not have medical indemnity. [RA1]

Leadership and culture

On the day of inspection the provider demonstrated that they had clinical experience, however unable to demonstrate they had capacity and capability to lead the practice and ensure policies and processes were in place to support delivery of high quality care. The provider had recognised the need for an effective leadership structure and was in discussions with the CCG regarding further support and guidance.

The provider was aware of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) however there were gaps in the systems to ensure compliance with the requirements. For example there were no evidence of training for all staff on communicating with patients about notifiable safety incidents. We saw that there were gaps in the systems for when things went wrong with care and treatment. For example:

- Although the practice received patients safety alerts from Walsall CCG, when asked the practice were unable to provide evidence of where these had been reviewed and acted upon. Staff we spoke with told us that they were not receiving medication and devices alerts, we were also told that the practice were not signed up to receive MHRA alerts.
- There were no evidence that the practice gave affected people reasonable support, truthful information and a verbal and written apology.

There was gaps in the leadership structure however staff we spoke to told us they felt supported by management.

- Staff we spoke with told us the practice were not holding regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported. Staff we spoke to told us that they felt more supported now that a new management structure had been put in place. Staff also told us that they were looking forward to the new training plan which the practice were implementing.

Are services well-led?

Inadequate

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

- We saw that there was an action plan in place to address issues such as recruitment, staff development, re engagement with the PPG, introduce patient care plans and review practice policies and procedures.

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

We were told that the practice PPG stopped meeting a few years ago therefore there were no active patient participation group; as a result the practice were unable to demonstrate how they encouraged and valued feedback from patients, the public and staff. When asked we were told that the practice were attempting to contact previous members to see whether they were interesting in forming a group. During our observations we saw there were no notices up in the reception area or clinical rooms promoting patient engagement. There were no evidence of the practice proactively seeking patients' feedback and engaging patients in the delivery of the service. Staff we spoke with told us that there were no internal surveys carried out and no changes recorded as a result of the friends and family test.

We were told that the practice were not gathered feedback from staff and were not holding staff meetings or conducting appraisals. However staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example staff told us they raised a concern with the GP regarding practice incoming mail, as a result we were told that a new process were implemented to manage incoming mail. Staff we spoke to also told us that the practice responded the high volume of phone calls received during the morning by introducing a prescription request form which patients hand to reception; as a result this cleared the phone lines for patients to make GP appointments. Staff told us they felt they would be involved to improve how the practice was run.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure clear care and/or treatment plans, which includes agreed goals, were developed and made available to all staff and others involved in providing the care. This was in breach of regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure the practice worked in partnership with other relevant bodies to contribute to individual risk assessments, developing plans for safeguarding children and safeguarding adults at risk, and when implementing these plans. The safeguarding lead was not attending multidisciplinary meetings. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

The registered person did not do all that was reasonably practicable to establish and operate effectively an accessible system for identifying, receiving, recording, handling, responding and learning from complaints.

The registered manager did not ensure Information and guidance about how to complain were available and accessible to everyone who uses the practice.

This was in breach of regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure staff received appropriate support, training, professional development and appraisal as is necessary to enable them to carry out the duties they are employed to perform. For example staff that carried out chaperoning were not trained and unclear of the guidelines regarding this duty. The safeguarding and infection control lead had not received the level of training required to carry out this role. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure robust recruitment and selection

This section is primarily information for the provider

Requirement notices

checks that comply with the requirements of this regulation were in place. For example there were gaps in staff files such as proof of identification, proof of employment history and references.

The practice did not have processes in place to check that staff have appropriate and current registration with professional regulators.

This was in breach of regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.