Tile Cross 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tile Cross Surgery on 5 May 2016. Overall the practice is rated as requires improvement. There are two surgery locations that form the practice; these consist of the main practice at Church Road and the branch practice at Tile Cross Surgery. Systems and processes are shared across both sites. During the inspection we visited both locations. As the locations have separate CQC registrations we have produced two reports. However where systems and data reflect both practices the reports will contain the same information.

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

- The practice had defined and embedded systems in place to keep people safeguarded from abuse. There was a system in place for reporting and recording significant events and staff we spoke with were aware of their responsibilities to raise and report concerns, incidents and near misses.
- We observed the premises to be clean and tidy, but the building was situated in a residential area which posed difficulties for parking and access.
- The practice had reviewed its fire evacuation procedures with the local fire officer to ensure that robust systems were in place.
- Clinical audits were carried out to demonstrate quality improvement and to improve patient care and treatment and results were circulated and discussed in the practice.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. Some staff had not received regular appraisals.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was limited information on display about local services and no details of carers groups or support organisations were available.

Summary of findings

- Information about how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Due to resignation of four GP Partners, the practice had employed locums to ensure that appointments were available daily.
- There was a clear leadership structure and staff felt supported by management.
- The provider was aware of and complied with the requirements of the duty of candour.
- Governance and risk management arrangements were in place, but were not operating effectively and therefore the provider did not have appropriate oversight of risk. For example no risk assessments had been completed in the absence of disclosure and barring checks (DBS) for members of the reception team who occasionally chaperoned.
- Areas of poor performance in relation to QOF and screening had been considered with action plans in place to mitigate this.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. We saw evidence that quarterly multidisciplinary team meetings took place.

The areas where the provider must make improvements are:

The provider did not have effective systems to enable them to identify, assess and mitigate risks by;

- Seeking and acting on feedback received to demonstrate improvements to services.
- Keeping records to demonstrate that staff were up to date with the immunisations recommended for staff who are working in general practice, such as Hepatitis B, mumps and rubella (MMR) vaccines.
- Ensuring all staff are risk assessed in the absence of a Disclosure and Barring Service (DBS) check when carrying out chaperoning duties.

Patients were not protected against the risks associated with receiving unsafe care or treatment in that;

- Patient Specific Directions were not in place for patients who received vaccinations by the Health Care Assistant.

The areas where the provider should make improvement are:

- Ensure staff who chaperone are aware of and comply with recommended chaperoning guidelines when observing treatments and examinations.
- Have information available for patients on support groups and services available in the local area.
- Review current processes for ensuring patients with a learning disability receive annual health checks.
- Ensure that staff are informed and involved in the overall vision of the practice.
- Complete appraisals for all staff including development plans.
- Monitor quality and outcome framework (QOF) indicators to ensure patient reviews are up to date and completed.
- Continue to review the registers for patients with long term conditions and mental health needs to ensure appropriate reviews are in place.
- Consider how to proactively identify and support carers.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

- There was an effective system in place for reporting and recording significant events. The staff we spoke with were aware of their responsibilities to raise and report concerns, incidents and near misses.
- The practice had defined and embedded systems in place to keep people safeguarded from abuse. Staff demonstrated they understood their responsibilities and how to respond to a safeguarding concern.
- We observed the premises to be clean and tidy and we saw completed cleaning schedules to demonstrate that the required cleaning had taken place for each area of the practice.
- Systems were in place to ensure the safe storage of vaccinations and evidence to demonstrate that checks were undertaken to monitor the vaccines.
- Patient Specific Directions were not in place for patients who received vaccinations by the Health Care Assistant.
- Equipment required to manage foreseeable emergencies was available and was regularly serviced and maintained.
- The practice had not formally assessed the risk in the absence of Disclosure and Barring Service (DBS) checks for members of the reception team who would occasionally act as chaperones.
- The practice policy and process did not reflect national guidance for chaperoning.

Are services effective?

Requires improvement

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were low in several areas compared to the national average. For example the practice achieved 83.1% for depression related indicators which was lower than the CCG average of 96.6% and the national average of 92.3%. The practice attributed the low QOF scores to lower exception reporting.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment and with the reduction in clinical staff, the two remaining GP Partners had supported the staff to continue to offer a full service to the practice population.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Summary of findings

Are services caring?

Good

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice offered flexible appointment times based on individual needs and we saw evidence of how the practice had responded to the needs of vulnerable patients with compassion and empathy.
- There was limited information available for patients about the services available in the local area.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the provider ran an anti-coagulation clinic for patients who were on warfarin at both Tile Cross and Church Road sites.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.
- The practice had limited opening times, but patients could access appointments from 8am to 6.30pm at Church Road surgery.
- There were longer appointments available at flexible times for people with a learning disability and for patients experiencing poor mental health. Same day appointments were also available for children and those who needed to see a doctor urgently.
- No equality assessment had been completed to identify how patients would be supported in the absence of a hearing loop. The practice could identify patients who had hearing difficulties and alerts were added to patients' records.
- 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 opening hours and telephone access.

Summary of findings

Are services well-led?

Inadequate

- The practice had a vision and strategy to deliver quality care and promote good outcomes for patients, but this was not supported by the poor performance in relation to QOF and screening. The practice attributed the low QOF results to low exception reporting. An action plan had been discussed to mitigate this.
- Staff spoke positively about the team and about working at the practice, but not all staff members were familiar with the practice vision.
- There was a clear leadership structure and staff felt supported by management.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.
- The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- Meetings with the whole practice team had not been regular due to the change in staffing structure.
- The practice had a number of policies and procedures to govern activity, but governance arrangements were not robust enough to mitigate risk, for example disclosure and barring (DBS) checks.
- The practice did not proactively seek feedback from patients; however they had recently formed a combined patient participation group to receive patients' views with representation from both Tile Cross and Church Road sites.
- All staff had received inductions but not all staff had received regular performance reviews or attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- Patients 75 and over were being notified of their named GP and the practice carried out twice weekly ward rounds at the local nursing home.
- The practice had systems in place to identify and assess patients who were at high risk of admission to hospital. There were 1% of patients on the unplanned admissions list and we saw evidence that every new patient received a care plan. Patients who were discharged from hospital were reviewed within 24 hours of being discharged from hospital to establish the reason for admission. Patients were reviewed and care plans were updated.
- The practice worked closely with multi-disciplinary teams so patients conditions could be safely managed in the community.

People with long term conditions

Requires improvement

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The latest QOF results showed performance for chronic pulmonary obstructive disease (COPD) indicator was 69.7%, which was lower than the national average of 96%. The practice attributed the lower QOF scores to low exception reporting.
- Longer appointments and home visits were available when needed and housebound received reviews and vaccinations at home. For example, blood tests for warfarin monitoring were carried out by the Health Care Assistant.

Summary of findings

- Patients with a long term conditions had a named GP and a structured annual review to check their health and medicines needs were being met.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- 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.
- The practice ran an In house diabetes clinic with the support of a hospital consultant at both Tile Cross and Church Road.

Families, children and young people

Requires improvement

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

- The practice's uptake for the cervical screening programme was 74% which was lower than the national average of 82%.
- The practice held nurse-led baby immunisation clinics and vaccination targets, but results were lower than the national averages.
- Urgent appointments were available for children and were also available outside of school hours.
- The premises were suitable for children and babies. We saw positive examples of joint working with midwives and health visitors and the midwife held an ante natal clinic once a week at the practice.

Working age people (including those recently retired and students)

Requires improvement

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Summary of findings

- A full range of health promotion and screening that reflected the needs for this age group was also available. It provided a health check to all new patients and carried out routine NHS health checks for patients aged 40-74 years.
- The practice provided an electronic prescribing service (EPS) which enables GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- Early morning appointments were available for patients who could not attend during normal surgery hours.

People whose circumstances may make them vulnerable

Requires improvement

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

- The practice offered longer appointments for patients who required them.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. We saw that there were 46 patients on the learning disability register and ten patients had received an annual health checks. The practice attributed the low number of health checks to staff shortages and patients not attending their appointments despite reminders being sent. .
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice held a register of carers and had 171 carers registered, which represented 1.49% of the practice list. On further investigation we found that the GPs were unsure of the correct coding to use to identify carers on the clinical system.
- Patients were unaware of what support and organisations were available due to lack of information being available in the waiting room and reception areas.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement 

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

- The practice had 103 patients on the dementia register and 76.9% had had their care reviewed in a face to face meeting in the last 12 months, which was lower than the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and offered same day appointments.
- The practice held a register of patients experiencing poor mental health; a low number had received a regular review. We saw that there were 91 patients on the mental health register and 76.5% had had care plans agreed.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results were lower than the local and national averages. 287 survey forms were distributed and 120 were returned. This represented 38% response rate.

- 47% of patients found it easy to get through to this practice by phone compared to the CCG average of 68%, national average of 73%.
- 70% of patients were able to get an appointment to see or speak to someone the last time CCG average of 83%, national average of 85%.
- 78% of patients described the overall experience of this GP practice as good, CCG average of 83%, national average of 85%.
- 66% of patients said they would recommend this GP practice to someone who has just moved to the local area, CCG average of 75%, national average of 78%.

On the day of the inspection we spoke with two patients. One patient said they were satisfied with the care they received and thought staff were approachable and caring, but the second patient told us they had had great difficulty in getting an appointment with a nurse since March 2016.

The results of the Friends and Family test were 87% of patients were extremely likely or likely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

The provider did not have effective systems to enable them to identify, assess and mitigate risks by;

- Seeking and acting on feedback received to demonstrate improvements to services.
- Keeping records to demonstrate that staff were up to date with the immunisations recommended for staff who are working in general practice, such as Hepatitis B, mumps and rubella (MMR) vaccines.
- Ensuring all staff are risk assessed in the absence of a Disclosure and Barring Service (DBS) check when carrying out chaperoning duties.

Patients were not protected against the risks associated with receiving unsafe care or treatment in that;

- Patient Specific Directions were not in place for patients who received vaccinations by the Health Care Assistant.

Action the service SHOULD take to improve

- Ensure staff who chaperone are aware of and comply with recommended chaperoning guidelines when observing treatments and examinations.
- Have information available for patients on support groups and services available in the local area.
- Review current processes for ensuring patients with a learning disability receive annual health checks.
- Ensure that staff are informed and involved in the overall vision of the practice.
- Complete appraisals for all staff including development plans.
- Monitor quality and outcome framework (QOF) indicators to ensure patient reviews are up to date and completed.
- Continue to review the registers for patients with long term conditions and mental health needs to ensure appropriate reviews are in place.
- Consider how to proactively identify and support carers.

Tile Cross 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 adviser and a practice manager specialist adviser.

Background to Tile Cross Surgery

Tile Cross Surgery is based in Tile Cross area of the West Midlands. There are two surgery locations that form the practice; these consist of the main practice at Church Road and the branch practice at Tile Cross Surgery. There are approximately 11460 patients of various ages registered and cared for across the practice and as the practice has one patient list, patients can be seen by staff at both surgery sites. Systems and processes are shared across both sites. During the inspection we visited both locations. As the locations have separate CQC registrations we have produced two reports. However where systems and data reflect both practices the reports will contain the same information.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care. The practice also provides some enhanced services such as minor surgery, childhood vaccination and immunisation schemes. The practice runs an anti-coagulation clinic for the practice patients.

There are two GP partners (one male, one female) and two female salaried GPs. The practice has undergone significant upheaval in the last nine months with the resignation of four GP partners, a practice nurse and the retirement of another practice nurse. The practice has employed a new salaried GP and two practice nurses recently. The nursing team currently consists of three nurses and two health care assistants. Another practice nurse is due to start in June 2016. The non-clinical team consists of a practice manager, assistant practice manager, administrative and reception staff. The clinical staff worked across both sites.

The area served has higher deprivation compared to England as a whole and ranked at three out of ten, with ten being the least deprived.

The practice is open 8am to 6.30pm Monday and Wednesday, 8am to 1pm Tuesday, Thursday and Friday. When Tile Cross surgery is closed, patients can access appointments at the Church Road site. Extended hours appointments are available 7.30am to 8am Monday to Friday. Emergency appointments are available daily. Telephone consultations are also available and home visits for patients who are unable to attend the surgery. The out of hours service is provided by Badger Out of Hours Service and NHS 111 service and information about this is available on the practice website.

The practice is part of NHS Solihull Clinical Commissioning Group (CCG) which has 38 member practices. The CCG serve communities across the borough, covering a population of approximately 238,000 people. A CCG is an NHS Organisation that brings together local GPs and experienced health care professionals to take on commissioning responsibilities for local health services.

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 5 May 2016. During our visit we:

- Spoke with a range of staff including GPs, practice manager, practice nurse, health care assistant and receptionists and with patients who used the service.
- Observed how patients were being cared for and talked with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The staff we spoke with were aware of their responsibilities to raise and report concerns, incidents and near misses. Staff talked us through the process and showed us the reporting templates which were used to record significant events. We viewed a summary of seven significant events between both sites that had occurred since July 2015. The practice kept a record of significant events on the shared drive for all staff to review actions taken and lessons learnt. Significant events, safety alerts, comments and complaints were a standing item on the weekly partner meeting agendas and we reviewed minutes of meetings where these were discussed. Full staff meetings had not been held regularly due to the changes in staffing at the practice; however outcomes of meetings were added to the shared drive for all staff to access. Staff we spoke with were aware of where minutes were held and were able to demonstrate and discussed incidents that had occurred and actions that had been taken.

There was an effective system in place for recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support and a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed and actioned appropriately. We saw evidence that lessons were shared and action was taken to improve safety in the practice.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level 3. One of the GPs was the lead member of staff for child and adult safeguarding and they attended quarterly safeguarding meetings and provided reports where necessary for other agencies.
- There was no notice available to advise patients that chaperones were available if required. Some of the reception team and health care assistants would act as a chaperone when required. There had been no risk assessment completed to determine if Disclosure and Barring Service (DBS) checks were required for members of the reception team who acted as chaperones. On speaking with staff concerning chaperone duties it was apparent that nationally recognised guidance, such as the General Medical Council (GMC) chaperoning guidelines was not being adhered to.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the GPs and a practice nurse were the infection control clinical leads who liaised with the local infection prevention teams to keep up to date with best practice. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The latest audit had been completed in February 2016 and the practice had achieved 99%. There was an infection control protocol in place however the practice did not keep records to support that staff were up to date with the immunisations recommended for staff who are working in general practice, such as Hepatitis B, mumps and rubella (MMR) vaccines.
- 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). The vaccination fridge temperatures were recorded and

monitored in line with guidance by Public Health England. Processes were in place for handling repeat prescriptions which included the review of high risk medicines.

- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with national legislation. PGDs are written instructions for the supply or administration of medicines to groups of patients. We saw the latest copies of PGDs and evidence that the practice nurses had received appropriate training to administer vaccines. The practice also had a system for production of Patient Specific Directions to enable the healthcare assistants to administer vaccinations; however one of the Health Care Assistants informed us that these had not been used during the last flu campaign.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription stationery was securely stored and there were systems in place to monitor their use.
- There were systems in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. The practice used an electronic prescribing system and all prescriptions were reviewed and signed by a GP before they were given to the patient and there were systems in place to monitor their use. Any prescriptions that were not collected were reviewed by the GPs for further action. Medicine safety alerts were sent to all relevant staff and necessary actions were taken in accordance with the alerts such as individual reviews of patients who may have been prescribed a particular medicine.
- 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.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body.

Monitoring risks to patients

- There was a health and safety policy available and a health and safety risk assessment had been completed in March 2016. The practice had fire training planned and confirmed for June 2016. The last fire drill was carried out in August 2015. The practice had up to date fire risk assessments, that had recently been reviewed with the local fire officer and we saw evidence of quarterly checks being carried out on the fire alarms and emergency lighting. All electrical equipment was checked annually to ensure the equipment was safe to use, the last service had been in May 2015. Clinical equipment was checked to ensure it was working properly annually; the last review had been in June 2015.
- The practice had some risk assessments in place to monitor safety of the premises such as infection control. For legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) the last risk assessment had been completed in February 2014.
- All locum doctors and nurses employed by the practice have had all the necessary checks completed.
- 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 enough staff were on duty. Due to staff shortages the practice had been using temporary doctors and nurses to support patients until new staff were recruited.

Arrangements to deal with emergencies and major incidents

The practice had adequate 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.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- 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.

Requires improvement

Are services safe?

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed 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.

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

Management, monitoring and improving outcomes for people

The 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 86.6% of the total number of points available, with 4.3% exception reporting, this was lower than the national average of 94.8% and national exception reporting of 9.2%. (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).

This practice was an outlier for some QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was 89.3% which was similar to the national average of 89.4%.
- Performance for mental health related indicators was 76.6% which was lower than the national average of 92.8%.
- Performance for chronic pulmonary obstructive disease (COPD) was 69.7% which was lower than the national average of 96%.

The practice attributed the low performance indicators to low exception reporting.

- There had been four clinical audits undertaken in the last twelve months, two of these were completed audits where the improvements made were implemented and monitored. For example, one audit in July 2015 reviewed patients who were receiving a medicine prescribed for those who had impaired renal function. The audit identified 13 patients who required a medication review. The audit was repeated in February 2016 and no patients were identified as being on the medicine.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

The practice worked closely with the practice pharmacists to ensure appropriate prescribing and with the nursing team to review and monitor patients with long term conditions.

The practice maintained a register for carers, patients requiring end of life care, patients with a learning disability, mental health condition and patients with a cancer diagnosis.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were not continually identified, as appraisals and staff meetings were not held regularly. Staff had access to training to cover the scope of their work. For example, both health care assistants had recently completed a sample taking course to support the nurses with the anti-coagulation clinic. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Staff received mandatory training that included: safeguarding, fire safety awareness, basic life support and information governance.

Requires improvement

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice carried out weekly ward rounds at the local nursing home and on the day of the inspection we spoke with the nursing home managers and the palliative care nurse who told us that the practice was supportive and held regular meetings with them. Meetings took place with other health care professionals on a quarterly basis when care plans were routinely reviewed and updated 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 understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 74.13%, which was lower than the CCG average of 81% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. 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.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice had achieved the following:

- 57% for patients aged 60-69 years, had attended screening for bowel cancer in the last 30 months, which was comparable to the national average of 58%
- 73% for female patients aged 50-70 years, had attended screening for breast cancer in last 36 months, which was comparable to the national average of 72%.

Childhood immunisation rates for the vaccinations given were below CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 78% to 91% and five year olds from 83% to 92%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

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.

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

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 94% of patients said they had confidence and trust in the last GP they saw, compared to the CCG average of 95%, and the national average of 95%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern, compared to the CCG average of 91% and national average of 91%.

The practice scored lower for the following satisfaction scores:

- 81% of patients said the last GP they spoke to was good at treating them with care and concern, CCG average of 85%, national average of 85%.
- 82% of patients said the GP gave them enough time, CCG average of 87%, national average of 87%.
- 75% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86%, national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care CCG average of 85%and the national average of 85%.
- 93% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 90%.

Some results were lower than local and national averages. For example:

- 73% of patients said the last GP they saw was good at involving them in decisions about their care, CCG average of 79%, national average of 82%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- There was no hearing loop available, however staff could identify patients who had hearing difficulties and alerts were also added to the patients' record and patients were assisted to the consulting rooms if required.

Patient and carer support to cope emotionally with care and treatment

Information about support groups was available on the practice website, for example Arthritis care. There were no patient information leaflets and details of organisations and support groups including support and advice for carers available in the patient waiting area.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 171 patients as

Good

Are services caring?

carers, which represented 1.49% of the practice list. The numbers on the register were low and on speaking with the GPs, they were aware that consistency was needed in the coding of carers.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered early morning appointments Monday to Friday morning from 7.30am to 8am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and patients experiencing poor mental health.
- The practice offered a range of clinical services which included care for long term conditions such as diabetes and anti-coagulation clinics, a range of health promotion and the midwife offered antenatal appointments once a week.
- There were disabled facilities and translation services available.
- Clinical staff conducted ward rounds at the local nursing home and home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients could book appointments over the telephone or online. The practice also used an electronic prescription service.
- Same day appointments were available for children and those patients with medical problems that required a same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and those vaccines only available privately were referred to other clinics.

Access to the service

The practice was open between 8am and 6.30pm Monday and Wednesday, 8am to 1pm Tuesday, Thursday and Friday. Appointments were from 8am to 11.30am on Monday, 8am to 12pm Tuesday, Wednesday and Friday and 8am to 11am Thursday. Afternoon appointments were available on Monday and Wednesday from 3pm to 5pm. Extended hours appointments were offered from 7.30am to 8am every weekday morning. Patients could also access appointments at Church Road surgery from Monday to Friday 8am to 6.30pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available each day for people that needed them.

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

- 60% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and the national average of 75%.
- 47% of patients said they could get through easily to the practice by phone, CCG average of 68% and the national average of 73%.

Results from the national GP patient survey for waiting times at the practice was higher than the local and national averages for these areas:

- 76% usually wait 15 minutes or less after their appointment time to be seen compared with the CCG average of 61% and the national average of 65%.
- 67% of patients felt they did not normally have to wait too long to be seen, compared with the CCG average of 55% and the national average of 58%.

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.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system on display in the waiting room and complaints procedure was available from the reception staff.
- We looked at five complaints received in the last 12 months between both sites and found these were satisfactorily handled and dealt with in a timely way.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision and strategy to deliver quality care and promote good outcomes for patients, but this was not supported by the poor performance in relation to QOF indicators and screening uptakes. The practice attributed the low QOF scores to lower exception reporting. An action plan had been discussed to mitigate this.

- The practice had a strategy, but no business plans were in place to reflect the vision and values and some of the staff we spoke with were unaware of the practice vision.
- The provider was in the process of recruiting new clinical staff to the practice to improve service provision. The practice has used agency nursing staff and locum GPs to minimise waiting times for appointments.

Governance arrangements

Governance and risk management arrangements were in place, but were not operating effectively and therefore the provider was unable to offer assurances that risks were managed appropriately. For example no risk assessments had been completed in the absence of disclosure and barring checks (DBS) for members of the reception team who occasionally chaperoned.

The governance framework outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, and capability to run the practice. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

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

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues with the GPs and manager and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice.
- Staff told us the practice had not held regular team meetings since some of the partners had left, but staff said they were encouraged to identify opportunities to improve the service delivered at the practice.

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

The practice had recently held their first PPG meeting in April 2016 which included members from both Tile Cross and Church Road. The practice had not carried out any surveys since 2014 however used complaints received to gather feedback from patients. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt supported with the recent departure of four GP partners and two of the nursing staff.

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 **Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.** **How this regulation was not being met:** • The registered person did not have Patient Specific Directions (PSD) in place for patients who receive vaccinations by the Health Care Assistant. .

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 **Providers must assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.** **How this regulation was not being met:** • The registered person had not carried out the appropriate checks through the Disclosure and Barring Service (DBS) or completed risk assessments in the absence of a DBS check for staff who acted as a chaperone. • The registered person had not sought feedback from services users and completed actions to demonstrate improvements to services. • The registered person did not have up to date records to support that staff were up to date with the immunisations recommended for working in general practice.