Fiveways Health Centre

Quality Report

Ladywood Middleway
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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?	Good
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires Improvement

Are services responsive? – Good

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

People experiencing poor mental health (including people with dementia) - Inadequate

We carried out an announced comprehensive inspection at Five ways Health Centre on 9 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice had a system in place to manage risk; however we found the system was not always effective and did not ensure safety incidents were acted on appropriately. For example, there was limited information to demonstrate whether actions to improve safety as a result of learning had been made following incidents.
- The practice were unable to demonstrate effective management of risks in relation to medicine safety alerts or updates from the Medicines and Healthcare products Regulatory Agency (MHRA).
- The practice did not routinely review the effectiveness and appropriateness of care provided. Care and treatment was not always delivered according to evidence- based guidelines. For example, patients on high risk medicines were not reviewed regularly and patients on the learning disability register were not offered regular health checks.
- The practice did not adopt a systematic approach to determine the number of staff required in order to meet the needs of people using the services. For example, the practice was reliant on regular locums which placed additional pressure on the principal GP.

Summary of findings

- Non-clinical staff were exception reporting patients without clinical input or oversight. The GP reported they had no involvement in this process and were unaware of the high exception reporting rates.
- The health care assistant (HCA) was adding medicines to patients records for the prescriptions to be signed by the GP. We were told that before adding medicines the HCA discussed each patient with the GP. However when reviewing patients' records, we found that this was not clearly documented.
- Emergency medicines were available and all staff were aware of their location. We found one medicine was not in place, however this was immediately purchased.
- The practice had systems, processes and practices in place to keep people safe and safeguarded from abuse.
- We found some clinical audits had been completed; however, audits did not demonstrate quality improvements.
- There was a leadership structure and staff felt supported by management; however effective oversight to ensure governance arrangements were embedded had not been established. For example, practice policies such as collection of prescription protocol was not being followed; systems for preventing and controlling the spread of infections was not always being carried out.
- We found limited clinical leadership within the practice and clinical tasks were being completed by administration staff. For example: the review and actioning of clinical letters.
- Uptake for childhood immunisations and national screening programmes were below national averages.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Feedback from patients from the national GP patient survey and the CQC patient comment cards showed that they felt they were treated with compassion, kindness, dignity and respect and felt involved in their care and treatment.
- There was little evidence of innovation or service development and improvement was not being explored or discussed among staff and the management team.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Encourage patients to attend immunisation and national screening programmes.
- Continue to review how the practice could proactively identify carers in order to offer them support where appropriate.
- Review the current processes for engaging with the practice population to encourage patients to feedback on services.
- Monitor complaints and comments received to identify trends.

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

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

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

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Encourage patients to attend immunisation and national screening programmes.
- Continue to review how the practice could proactively identify carers in order to offer them support where appropriate.
- Review the current processes for engaging with the practice population to encourage patients to feedback on services.
- Monitor complaints and comments received to identify trends.

Fiveways Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, two practice nurse specialist advisers and a second CQC inspector.

Background to Fiveways Health Centre

Five ways Health Centre is located in Ladywood Middleway, central Birmingham. The surgery operates out of a purpose-built premises.

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 and is a nationally agreed contract. The practice also provides some enhanced services such as childhood vaccination and immunisation schemes.

The practice provides primary medical services to approximately 4,500 patients in the local community. The lead GP (female) has the support of GP locums, a part time practice nurse (female) and health care assistant (male). The non-clinical team consists of administrative and reception staff and a practice manager.

Based on data available from Public Health England, Five Ways Health Centre is located in a area with high levels of deprivation compared to the national average. For example, the practice is ranked one out of 10, with 10 being the least deprived and 59% of people in the practice area were from black and minority ethnic (BME) groups. The practice had a lower than national average of patients aged over 65 years, with the practice currently having registered 8% of its population in this age group in comparison to the national average of 17%.

The practice is open between 8am to 8pm Mondays to Fridays and 10am to 12 Midday Saturday and Sunday. Appointments with the are from 9.30am to 12.30pm and 4pm to 6.30pm on Monday to Friday. Extended hours appointments are available Monday to Friday 6.30pm to 7pm and 10am to 11.30am Saturday and Sunday. Telephone consultations are available if patients requested them; home visits were also available for patients who are unable to attend the surgery if they were within the practice boundaries.

When the practice is closed, primary medical services are provided by Primecare, an out of hours service provider and the NHS 111 service and information about this is available on the practice website.

The practice is part of NHS Sandwell & West Birmingham CCG which has 91 member practices. The CCG serve communities across the borough, covering a population of approximately 559,400 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).

Inadequate

Are services safe?

Our findings

We rated the practice as inadequate for providing safe services overall and across all population groups.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had completed training relevant to their role in this area. GPs were trained to child safeguarding level three.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- We were told on the day of inspection that the practice nurse was the clinical infection control lead; however we found no evidence to confirm that the practice nurse had completed the appropriate training for this role and the infection control policy did not detail who was the lead for the practice. There were cleaning schedules and monitoring systems in place for the premises and for some items of clinical equipment, however we could not find any record of cleaning of the ear irrigation equipment. We also found a spillage kit to use for the spillage of body fluids was out of date.
- The practice manager advised us that they regularly use locum GPs including the practice nurse. We checked the personnel files for members of staff (one of which was the long term locum nurse). During the inspection we saw the majority of staff checks were in place but we found no immunisation status recorded for the practice nurse and no risk assessment in place in the absence of this information. Following our inspection, the practice provided evidence of immunisation status.
- The practice ensured that facilities and some equipment were safe. There were systems for safely managing healthcare waste, although we found that not all sharps waste was appropriately segregated and no steps had been taken to protect the vaccine fridge from accidental interruption of the electricity supply in line with Public Health England guidance such as labelling the fridge plug appropriately.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety; however formal arrangements to ensure continuity of clinical cover over the long term had not been clearly established.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. A template for suspected sepsis in line with evidence based guidance was available for clinicians to use. We found the practice did not have a paediatric pulse oximeter to enable assessment of patients with suspected sepsis.
- Emergency medicines and equipment including a defibrillator (with child and adult pads) and oxygen were available. The pads had expired in January 2017 and records showed that the staff member responsible had requested the new pads several months before, however these had not arrived and we saw no action to follow up on the delay. We found on the day of inspection that one of the emergency medicines used for the treatment of patients who develop a slow heart rate following an IUCD implant (intrauterine contraceptive device) was not available. On the day of inspection, the provider immediately purchased the emergency medicine. There was an instant messaging system in place for alerting all staff to an emergency.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan contained details of emergency contacts and staff contact details.

Inadequate

Are services safe?

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients, however we found the system was not effective in managing patients' needs.

- Individual care records were written in a way that kept patients safe; however the care records we saw showed that information needed to deliver safe care and treatment was not always acted on.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- We found patient information such as hospital discharge information was not acted on appropriately; administration staff reviewed hospital correspondence with very limited clinical input, which had caused delays in patients' receiving timely referrals to other services.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had some systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice completed a daily log of the vaccine fridge temperatures; however we found one temperature that had been recorded outside of the required guidelines and no action had been taken in line with the practice policy.
- Patients' health was not monitored effectively to ensure medicines were being used safely and followed up on appropriately. This included patients on high risk medicines where we found evidence that the appropriate monitoring had not been completed before medicines had been prescribed.
- The health care assistant (HCA) was adding medicines to patients records for the prescriptions to be signed by the GP. We were told that before adding medicines the HCA discussed each patient with the GP. However when reviewing patients' records, we found that this was not clearly documented.
- The practice kept prescription stationery securely, however we found the practice were not adhering to their policy of monitoring prescription collection with a review every three months of uncollected prescriptions. On the day of inspection we found prescriptions that were over four months old awaiting collection had not been acted on.
- We found the vaccination schedule on display for staff who administered vaccines was two years out of date.
- Patient Group Directions (PGD) were in place to allow the practice nurse to administer medicines in line with legislation and patient specific directions (PSD) were produced and signed for the health care assistant to administer medicines within his role. (A PSD is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis).

Track record on safety

- There were comprehensive risk assessments in relation to safety issues.
- The practice had a range of risk assessments and policies in place for the premises including fire and legionella.

Lessons learned and improvements made

- There was a system for recording significant events and incidents, however we found the system was not effective in demonstrating what actions had been taken to minimise future risk.
- Staff understood their duty to raise concerns and report incidents and near misses and we saw evidence that these were discussed at monthly meetings, however the practice were unable to demonstrate what learning had taken place from these discussions .
- The system in place was not adequate for reviewing and investigating when things went wrong. The practice could not demonstrate they had learned from incidents, identified themes or taken action to improve safety in the practice. For example we found two examples of abnormal blood test results that had not been acted on.
- Safety alerts were received by the practice manager and forwarded on to the GP for action. We found the service could not demonstrate effective management of risks in relation to medicine safety alerts or updates from the Medicines and Healthcare products Regulatory Agency (MHRA). For example: An alert from the MHRA highlighted a risk relating to a combination of specific medicines for patients of child bearing age. The alert indicated that patients on these medicines should be

informed of the risks of foetal abnormalities when pregnant and referred to a specialist for an alternative medicine if they plan to get pregnant. During our inspection there was evidence to demonstrate that the practice had received the alert and had been seen by the GP, however there was no evidence of actions taken.

To gain assurance that no patients were at risk we asked the practice to conduct a search on their patient record system during our inspection. The search highlighted a number of patients who were on this medicine but the risk was reduced as none of these patients were of childbearing age.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as inadequate for providing effective services and across all population groups. .

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice; however we found that clinicians did not always assess patients' needs and delivered care and treatment in line with current legislation, standards and guidance.

- Patients' needs were assessed, but we found on reviewing patients' care records that regular reviews were not being completed for vulnerable patients and patients on high risk medicines.
- We found the health care assistant (HCA) was managing patients with hypertension, relying on previous medical experience as a general practitioner. We found no evidence of a protocol in place to govern this arrangement and there was no GP oversight to define results and ensure appropriate action had be taken.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

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

- The practice offered personalised care to meet the needs of the older people in its population; however the management of medicines was not effective.
- The practice was responsive to the needs of older people, and offered home visits to patients and urgent appointments for those with enhanced needs.
- The practice had systems in place to identify and assess patients who were at high risk of admission to hospital. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Multi-disciplinary team meetings were held regularly and well attended by community teams, including district nurses.

People with long-term conditions:

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

- Patients with long-term conditions had an annual review to check their health and medicines needs were being met, however we found on the day of inspection that administration staff were excluding patients from calculations without any clinical oversight.
- Performance for diabetes related indicators overall was 94% compared to the CCG average of 90% and national average of 91%. The exception reporting rate for diabetes was 23% in comparison to the CCG and national average of 11%. (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). We reviewed five patients records on the diabetes register and found no valid reason had been documented to demonstrate the reason for the patient being excluded from the QOF calculations.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice could not demonstrate effective management of patients on high risk medicines. We found patients in receipt of prescriptions for medicines, which required closer monitoring, were not always receiving a review of their treatment in line with prescribing recommendations.

Families, children and young people:

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

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines were lower than the national target of 90%. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 67% to 84%.
- Immunisation rates for five year olds ranged from 67% to 94% which were lower than the national average of 88% to 94%. The practice told us they were trying to encourage patients to attend for immunisations.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

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

- The practice's uptake for cervical screening was 51%, which was below the 80% coverage target for the national screening programme. The practice were aware of the low target rates and told us that the female GP was trying to improve the uptake by discussing the benefits with female patients.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients aged 40-74 years of age had access NHS health checks. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

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

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- Information provided by the practice showed 16 patients on the learning disability register. We found on reviewing the patient care records that none of the patients had received an annual health review in the previous 12 months.

People experiencing poor mental health (including people with dementia):

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

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average. The practice had higher exception reporting rate of 18% for this clinical indicator in comparison to the national average of 10%.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 95% of patients experiencing poor mental health had received discussion and advice about alcohol consumption (CCG 92%; national 91%).

Monitoring care and treatment

The practice did not have a programme of quality improvement activity and we saw no evidence of routine reviews being completed to monitor the effectiveness and appropriateness of the care provided.

The most recent published Quality Outcome Framework (QOF) results were 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. The overall exception reporting rate was 18% compared with the CCG average of 9% and the national average of 10%.

We found on the day of inspection that administration staff were exception reporting patients on the clinical registers with no clinical input or support. On speaking with the principal GP, she told us she had no involvement in the process and were unaware of the high exception reporting rates; she explained she had limited capacity due to patient demand. The practice had significantly higher exception reporting rates for a number of clinical indicators than CCG and national averages. For example:

- The exception reporting rate for patients on the Chronic Obstructive Pulmonary Disorder (COPD) was 22% in comparison to the CCG average of 14% and the national average of 13%.
- The exception reporting rate for patients on the coronary heart disease register was 19% in comparison to the CCG average of 10% and the national average of 9%

Inadequate

Are services effective?

(for example, treatment is effective)

- The exception reporting rate for patients on the peripheral arterial disease register was 15% in comparison to the CCG and national average of 6%.
- The exception reporting rate for patients on the cancer register was 67% in comparison to the CCG average of 31% and the national average of 25%

The practice was not actively involved in quality improvement activity. We saw an example of a one cycle audit for non-steroidal anti-inflammatory medicines (NSAIDs) to review and reduce the use of these medicines on repeat prescriptions. The first cycle was completed in August 2017. The audit demonstrated 20 patients were on NSAIDs, with 15 patients in the high risk categories that required a review. The practice were unable to confirm what reviews had been completed and as a second cycle had not been completed by the time of the inspection the practice were unable to demonstrate what improvements had been made.

Effective staffing

There was some evidence that staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date, however we identified the learning needs of staff had not been reviewed or monitored appropriately.

- The practice did not understand the learning needs of staff and did not provide sufficient training to meet their needs. Staff were encouraged and given opportunities to develop, but there was limited evidence of support for staff who were being developed for new roles.
- There was an induction process for new staff, one-to-one meetings and evidence of yearly appraisals. We found there was limited clinical supervision and support for revalidation. The healthcare assistant had not completed the Care Certificate, but relied on his previous medical experience as a general practitioner. The practice did not ensure competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- The health care assistant had received no specific training for the administering of vaccines, but relied on previous medical training as a general practitioner.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received person-centred care, but we found some examples when care had not been co-ordinated appropriately when they moved between services.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, advice was given to patients with long term conditions should their condition deteriorate.
- Flu and shingles vaccinations were available to eligible patients.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Requires improvement

Are services caring?

Our findings

We rated the practice as requires improvement for providing caring services overall.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Results from the NHS Friends and Family Test showed 62% of patients would recommend the practice. This was based on 164 responses received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 382 surveys were sent out and 66 were returned. This represented about 1% of the practice population. The practice satisfaction scores on consultations with GPs and nurses were comparable to local and national averages. For example:

- 79% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 82% of patients who responded said the GP gave them enough time; CCG 81%; national average 86%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; CCG 93%; national average 95%.
- 77% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG 80%; national average 86%.
- 82% of patients who responded said the nurse was good at listening to them; CCG 87%; national average 91%.
- 82% of patients who responded said the nurse gave them enough time; CCG 87%; national average 92%.
- 94% of patients who responded said they had confidence and trust in the last nurse they saw; CCG 95%; national average 97%.
- 81% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; 85%; national average 91%.
- 87% of patients who responded said they found the receptionists at the practice helpful; CCG 60%; national average 71%.

The practice were unaware of the data and had not completed an analysis of the results. No in house surveys were carried out in the practice.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. Patients also had access to multi-lingual staff that might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers; notices were on display in the waiting room asking patients to advise reception staff if they had caring responsibilities. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 16 patients as carers (0.3% of the practice list).

Staff told us that if families had experienced bereavement, a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service was offered.

Requires improvement

Are services caring?

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

- 82% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 82% and the national average of 86%.
- 72% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG 76%; national average 82%.
- 81% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG 86%; national average 90%.
- 82% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG 82%; national average 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as good for responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. (For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments and open access clinic for patients that required same day appointments).
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example: Consulting rooms were all available on the ground floor. There was ramp access to ensure easy access for patients using wheelchairs and pushchairs.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.
- The health care assistant (HCA) held a daily open access clinic for patients that required same day appointments. The HCA would complete a history of symptoms and relevant health checks before the patient saw the GP. The HCA and staff told us this had improved waiting times and had improved access.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. A total of 382 surveys were sent out and 66 were returned. This represented about 1% of the practice population.

- 87% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 78%.
- 84% of patients who responded said they could get through easily to the practice by phone; CCG 60%; national average 71%.
- 82% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG 76%; national average 84%.
- 87% of patients who responded said their last appointment was convenient; CCG 72%; national average 81%.
- 82% of patients who responded described their experience of making an appointment as good; CCG 63%; national average 73%.
- 58% of patients who responded said they don't normally have to wait too long to be seen; CCG 46%; national average 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately, but we found the practice were unable to demonstrate what improvements had been made to the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Six complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints, but no analysis was carried out to identify trends. The practice were unable to demonstrate improvements had been made to the quality of care as a result of acting on complaints and concerns.

Are services well-led?

Inadequate

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

Our findings

We rated the practice as inadequate for providing well led services and across all population groups.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Due to the demands on the principal GP, we found lack of capacity in clinical leadership, delivering the practice strategy and addressing risks. The management team did not have the experience, capacity and skills to effectively lead the practice.
- There were arrangements for planning and monitoring the number of staff needed; however, there were no formal plans to reduce the reliance of locums to ensure continuity of care and clinical cover.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The lead GP and adminstrator were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. However we found on the day of inspection that the practice manager had delegated many of the roles within the practice to the administrator who did not have the relevant skills and experience.
- The practice did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients, but due to capacity issues this was not being achieved.

- The practice had not developed a vision or strategy jointly with patients, staff and external partners.
- The practice did not have effective monitoring in place to review progress.

Culture

The practice had a culture of sustainable care, but due to the lack of leadership this was not evident in some areas.

- All staff had received regular annual appraisals in the last year, however we found there were limited processes for providing all staff with the development they needed. There was also limited support for staff to meet the requirements of professional revalidation where necessary.
- We found staff were carrying out roles for which they had not received training. For example: Non-clinical staff were exception reporting patients without clinical input or oversight.
- Clinical staff were considered valued members of the practice team. Due to the demands on the principal GP, the doctor had limited time to evaluate their clinical work.
- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Openness, honesty and transparency were demonstrated when responding to complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance arrangements

The leadership and oversight of governance arrangements had impacted on the delivery of safe care and treatment, for example:

- Structures, processes and systems to support good governance and management were not clearly set out, understood or effective; this included the management of risk.
- Staff were clear on their roles and accountabilities including in respect of safeguarding, but the nominated clinical lead for infection prevention and control had not completed the relevant training and was present at the practice one day a week.
- Practice leaders had established policies, procedures and activities to ensure safety, but we found on the day of inspection that these were not being followed appropriately and the management team had not assured themselves that they were operating as intended.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, but we found this were not effective.

Are services well-led?

Inadequate

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

- There was an ineffective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- We found risks were being managed appropriately in relation to the premises. However we also found some areas where improvements were needed. This included risks relating to staffing and staff training and development.
- The practice did not have processes to manage current and future performance. Performance of employed clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders did not have an oversight of MHRA alerts and incidents.
- The practice were unable to demonstrate that clinical audit had a positive impact on quality of care and outcomes for patients. There was no clear evidence of action to change practice to improve quality.
- The practice were unable to demonstrate service developments and where efficiency changes were made, as input from clinicians to understand their impact on the quality of care was limited due to capacity issues.

Appropriate and accurate information

We found the practice reviewed and acted on appropriate and accurate information, however we did find evidence where information had not been actioned.

- Quality and operational information was used to ensure and improve performance. QOF data was used to support the follow up of patients with long term conditions, but due to non-clinical staff reviewing patients on clinical registers and exception reporting them, the practice were unable to demonstrate effective management of patients with long term conditions.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice submitted data or notifications to external organisations as required. For example in relation to safeguarding concerns
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice did not effectively involve patients and the public to support high-quality sustainable services.

- Views from patients and concerns were encouraged, the practice were unable to demonstrate how feedback they received had shaped services. Results from the national GP patient survey were either above or comparable to local averages; however, the practice did not analyse or review results to identify areas for further improvement.
- The practice told us they had an active patient participation group, however we were told the practice struggled to get patients to attend meetings and the last meeting had been held in June 2017. Since the inspection we have received minutes of a meeting that was held on the 5 January 2018.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

The practice were unable to demonstrate continuous improvement and we saw limited evidence of quality improvement.

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 **The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users.** **Systems were not in place for the monitoring and review of high risk medicines.** **How the regulation was not being met:** **Patients' treatment and care was put at risk due to inappropriate medicines management, the actioning of safety alerts, and acting on significant events. Staffs' were carrying out tasks that they did not have the competencies to do.** • Non clinical staff were reviewing all clinical letters to decide if the GP needed to see them. This had resulted in the failure to process an urgent referral. • Non clinical staff were exception reporting patients on the clinical registers with no clinical oversight, inadequate training or understanding. • Safety alerts including alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were not managed appropriately and the practice were unable to demonstrate what actions had been taken. • Patients on high risk medicines were not being reviewed appropriately before prescribing of medicines. • Significant events and incidents had not been investigated or acted on appropriately.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

The provider did not have systems and processes in place to assess and monitor the patients outcomes. No comprehensive audits had been completed to demonstrate quality improvement.

How the regulation was not being met:

- The provider did not have systems and processes in place to assess and monitor the patients outcomes. No comprehensive audits had been completed to demonstrate quality improvement.
- The provider did not actively seek the views of a wide range of stakeholders, including people who used the service. The provider was unable to demonstrate if they had analysed patient feedback and made improvements.
- Staff were carrying out roles that they had not received the appropriate training for and which were outside of their competencies.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • We found that the practice did not have sufficient procedures in place for the management of infection control, including the assessment of health care associated infections to ensure they were managed appropriately. • We found no actions had been taken on the receipt of safety alerts, including those from the Medicines and Healthcare products Regulatory Agency (MHRA) to review patients and ensure risks were minimised. • Care and treatment was not provided in a safe way. We found significant failings in the management of hospital correspondence • During the inspection we reviewed the QOF clinical registers, where we identified a number of patients who had been inappropriately excluded from the registers and therefore had not received the appropriate care and treatment. • Following the inspection, you had identified in excess of 100 additional patient letters where action was required. These actions had not been completed.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • There were no systems and processes in place to assess and monitor patients' outcomes. No comprehensive audits have been completed to demonstrate quality improvement. This omission had not been identified by an effectively operated system or process established to ensure compliance with the regulations.

This section is primarily information for the provider

Enforcement actions

- Patient feedback had not been sought. This omission had not been identified by an effectively operated system or process established to ensure compliance with the regulations.
- We found there were no embedded systems in place to demonstrate that the practice managed correspondence effectively. We found significant failings in the management of hospital correspondence.
- There was no effective systems in place to ensure safety alerts received were acted on appropriately We found the practice had a system to receive safety alerts, including those from the Medicines and Healthcare products Regulatory Agency (MHRA), however no actions had been taken to review patients and ensure risks were minimised.
- There was no system in place to ensure there was clinical input when exception reporting patients on the clinical registers. We found that the practice administrator was making decisions concerning the exception reporting of patients on the clinical registers without any supervision or clinical support. We also found significantly high exception reporting in a number of other areas including chronic obstructive airways disease, cancer and dementia.