Dr Peter Scott

Quality Report

406C Chester Road
Kingshurst
Birmingham
West Midlands
B36 0LF
Tel: 0121 770 3035

Date of inspection visit: 17 April 2015
Date of publication: 08/10/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Peter Scott also known as Chester Road Surgery on 17 April 2015.

The overall rating for the practice is inadequate. This is because the safe and well led domains were rated as inadequate. The practice is also rated as requires improvement for effective and responsive. The service was rated as good for caring for the population it served. It was also rated as inadequate for providing services for the care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people whose circumstances may make them vulnerable and people experiencing poor mental health because the concerns which led to these ratings apply to everyone using the practice, including all the population groups.

Our key findings were as follows:

- The practice had experienced a rapid increase in patient list size with an additional 1200 patients being accommodated in 2011 following the closure of a neighbouring practice. The increase in patients had caused considerable strain on current resources.
- Patients were at risk of harm because systems and processes were not in place to keep them safe.
- We saw that there was an infection control policy in place but it did not provide adequate guidance to staff. Staff training records did not show that they had undertaken any recent training in this area to enable them to support each other on infection control although we were told infection control e-learning training was currently being organised.
- The practice did not have robust systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. For example we found that the practice had not carried out a health

Summary of findings

and safety risk assessment and the practice did not undertake effective checks of the building and environment to properly identify any issues that needed to be addressed.

- Staff were inconsistent about reporting incidents, near misses and concerns and there was very limited evidence of learning and communication with staff when things went wrong.
- We found the provider did not have suitable arrangements in place to ensure that staff received appropriate training, professional development, supervision and appraisal. Training records were not managed in a way which made it easy to identify and monitor what training staff had received and whether they were up to date with attending the practice's mandatory courses.
- The practice could not provide us with any evidence to demonstrate that practice meetings were occurring on a regular basis. A GP told us that the GPs and practice manager had daily meetings, which were not minuted.
- The practice was unable to demonstrate that staff, other than the GPs had received a Disclosure and Barring Service (DBS) check. In the absence of these DBS checks, no risk assessments had been carried out by the practice.
- We found that patients were treated with respect and their privacy and dignity was maintained. Patients informed us they were satisfied with the care they received.
- The practice had limited formal governance arrangements to ensure they could assess and monitor the quality of the service they provided.

Areas of practice where the provider needs to make improvements.

The provider MUST:

- Ensure there is an effective system in place so that information and documentation required has been obtained before people start working at the practice to confirm if they are suitable to work with patients.
- Ensure suitable arrangements are in place to support staff to deliver care and treatment safely and to an appropriate standard by receiving professional development and appraisal.
- Ensure there are effective systems in place to identify, assess the quality of the service and manage risks in order to protect service users, and others, against the risks of inappropriate or unsafe care (by ensuring all risk assessments are in place for example in respect of health and safety).

Action the provider SHOULD take to improve:

- Ensure all staff acting as a chaperone have appropriate understanding of their duties and responsibilities
- Ensure staff are aware of the arrangements in place to access translation services should a future need arise for interpreting services.
- Ensure that any areas identified of improvement for infection control and prevention are implemented through effective action planning
- Ensure that the practice complaints process is clear and effective and makes it easy for patients to raise any issues or concerns and that the practice encourages feedback from patients in order to evaluate and improve.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again within six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services. Staff were inconsistent in their understanding of the systems for reporting incidents, near misses and concerns. Although the practice reviewed incidents when things went wrong, lessons learned were not communicated to ensure safety was monitored and improved. Patients were at risk of harm because systems and processes were not in place or were not implemented effectively in a way to keep them safe. For example, recruitment procedures, infection control systems and health and safety. There was insufficient information to enable us to understand and be assured about safety because there was inadequate monitoring and oversight to ensure risks were identified, assessed and managed.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or slightly above average for the locality. However, there was limited recognition of the benefit of an appraisal process for staff although evidence of support for additional training for the practice nurse was seen. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice positively for some aspects of care. Patients described the staff as friendly and helpful, and felt they treated them with compassion and dignity. Patients said they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. The practice had conducted a survey and was responding to some of the findings. It was working with the NHS England Area Team and Clinical Commissioning Group (CCG) to review information about the local population. Information about how to complain was not readily available for patients with patients not fully aware of how to progress concerns and complaints.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. The provider had considered the future direction of the practice in light of a

Summary of findings

further increase of patients wishing to join the practice and future partnerships. However, this had not been communicated with staff who were unable to express the vision or strategy of the practice. There were a number of newly acquired policies and procedures at the practice to govern activity, but these had not yet become established as the practice was in the process of undertaking a review of all policies. The practice did not hold regular governance meetings to discuss performance, quality and risks. We were told that there were daily meeting with GPs and the practice manager where arising issues were discussed, these were not minuted. Staff had not received regular performance reviews and did not have clear objectives.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people. This is because the provider was rated as inadequate overall. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had allocated a named GP for all patients over 75 years. Longer appointments and prioritisation of older patients waiting for appointments when clinically needed was available at the discretion of the practice. The practice premises had a consulting room located on the ground floor for those with mobility issues as well as a disabled toilet. Home visits were available to older patients who were unable to attend the practice. We found that the practice was performing above the clinical commissioning group average (CCG) for flu vaccinations of patients over 65 years and in line with the national average.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. This is because the provider was rated as inadequate overall. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Reviews of patients with long term conditions were in place. Patients were encouraged to attend for annual reviews to check that their health and medication needs were being met and to ensure their medicines remained relevant. Continuity of care was provided through the same GP and where needed home visits were available. There was evidence of multi-disciplinary working, for example in the care of complex diabetic patients which was shared with the community diabetic outpatient clinic.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. This is because the provider was rated as inadequate overall. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were some systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk. Immunisation uptake rates were relatively high for all standard childhood immunisations. The premises were accessible to patients with small children and baby changing facilities were available. Young children were prioritised for appointments.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). This is because the provider was rated as inadequate overall. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had recently started to offer online appointments and online repeat medications but uptake of this facility was currently low. Health promotion advice was offered by the healthcare assistant although there was limited accessible health promotion material available at the practice. The provider told us that additional health promotion information would be printed off as appropriate. Those aged 40 to 74 were invited to attend NHS health checks. The practice operated extended opening times with early morning and evening appointments available on one day each week. Telephone consultations were also arranged for patients who were unable to attend.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated inadequate for the care of people whose circumstances may make them vulnerable. This is because the provider was rated as inadequate overall. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register for patients living in vulnerable circumstances such as those with a learning disability and had undertaken health checks for this group of patients. Carers were also identified during the registration process and this information was coded in the clinical system. All staff members we spoke with knew how to recognise signs of abuse in vulnerable adults and children. Most 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). This is because the provider was rated as inadequate overall. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had a register to identify patients experiencing poor mental health and undertook annual health checks for this group of patients. We saw that there were care plans in place. The practice told us that they offered dementia screening and were able to

demonstrate how they would identify, refer and support a patient once diagnosis was confirmed. The practice supported patients experiencing poor mental health to access various support including local counselling services managed by the local NHS mental health service improving access to psychological therapies (IAPT).

Summary of findings

What people who use the service say

Prior to the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 26 completed cards where patients shared their views and experiences of the service. Patients commented they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five of the comment cards also mentioned that the premises could be improved especially the waiting area which patients noted as being too small with insufficient seating.

We looked at the National Patient Survey results published in January 2015. We saw that surveys were sent out to 303 patients with 100 of patients completing these. This was a 33% response rate. The data showed that the practice performed better than other local practices in respect of patients experience in getting through to this surgery by phone. 93% of respondents described this experience as good compared to a 68% local average. 75% of respondents were also able to get an appointment with a preferred GP compared to a 57% local average. However, the practice did not perform as well as other local practices in respect of patient satisfaction with waiting times to be seen. Although only 26% of respondents stated that they usually wait 15 minutes or less after their appointment time to be seen (compared to 61% local average), this was due to an open-access of first-come first-served policy in place for morning appointments. Local practice surveys indicated this type of access as being preferred by patients although this would often require waiting 15 minutes or more from the moment of attendance. This was consistent with results of the national GP survey where 82% of respondents described their experience of making an appointment as good (local average was 68% and the national average was 73%). 77% of respondents also stated that the last GP they saw or spoke to was good at involving them in decisions about their care compared to 80% local average.

The practice had a patient participation group (PPG) which consisted of 3 members. PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. The practice did not take minutes of PPG meetings but we were provided with the PPG's annual report which documented that the PPG had last met in March 2015. We saw from this report that in consultation with the PPG, some actions had been agreed by the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure there is an effective system in place so that information and documentation required has been obtained before people start working at the practice to confirm if they are suitable to work with patients.
- Ensure suitable arrangements are in place to support staff to deliver care and treatment safely and to an appropriate standard by receiving professional development and appraisal.
- Ensure there are effective systems in place to identify, assess the quality of the service and manage risks in order to protect service users, and others, against the risks of inappropriate or unsafe care (by ensuring all risk assessments are in place for example in respect of health and safety).

Action the service SHOULD take to improve

- Ensure all staff acting as a chaperone have appropriate understanding of their duties and responsibilities
- Ensure staff are aware of the arrangements in place to access translation services should a future need arise for interpreting services.
- Ensure that any areas identified of improvement for infection control and prevention are implemented through effective action planning

Summary of findings

- Ensure that the practice complaints process is clear and effective and makes it easy for patients to raise any issues or concerns and that the practice encourages feedback from patients in order to evaluate and improve.

Dr Peter Scott

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager advisor.

Background to Dr Peter Scott

Dr Peter Scott's practice is registered with the Care Quality Commission to provide primary medical services. The practice has a general medical service (GMS) contract with NHS England. Under the GMS contract the practice is required to provide essential services to patients who are ill and this includes chronic disease management and end of life care.

The practice is based within the Solihull Clinical Commissioning Group (CCG) area and operates from a detached property that has been converted and extended. It has a registered list size of approximately 3500 patients. The practice's patient population has a higher number of female patients between the ages of 20-24 and patients aged 50-54. Data from Public Health England shows that the practice is located in an area where income deprivation is higher than the England average.

The practice is run by a lead male GP (provider) with a full-time salaried female GP. We were told that a regular locum GP (male) worked at the practice when required. At the time of our inspection the female GP was away on leave and the locum GP provided the services for the day. Other practice staff included a healthcare assistant, practice nurse (who was not present on the day of the inspection), a practice manager, a medical secretary and three reception staff (one of whom also undertook duties as a cleaner).

The practice was open between the hours of 8am to 6pm on Monday, Tuesday, Thursday and Friday. The practice closed on Wednesday afternoons from 12.30pm. During the daytime when the practice phone lines are closed between 12.30pm and 4pm, cover is provided by 'Badger' who are an external out of hours service contracted by the local CCG. Extended opening hours were also provided by the practice on Wednesday mornings from 7am to 8am and Thursday evenings from 6:30pm to 7:30pm.

Why we carried out this inspection

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

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.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew about the service. We carried out an announced inspection on 17 April 2015. During our visit we spoke with some of the staff on duty. This included the GP, healthcare assistant, practice manager, medical secretary and a member of reception staff. We looked at a range of documents that were made available to us relating to the practice, patient care and treatment. We also spent some time observing how staff interacted with patients but did not observe any aspects of patients' care or treatment. Prior to the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 26 completed cards where patients shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not have effective systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We asked to see the incident book for recording of significant events which we had been told about but this could not be located by the practice. We also asked to see the accident book and only a recent one dated from January 2015 could be found which contained no recorded accidents. We were told a previous accident book existed but this could not be found. Additionally, one member of staff told us about an injury they had recently suffered but no records could be found. Staff we spoke with were not all aware that a log book for recording accidents and incidents was available at the practice. We did not see evidence that learning was shared with staff. This did not assure us that the practice had a safe track record over time.

The GP told us about a process set-up on the clinical system so that any patient safety alerts were appropriately responded to. We were told that patient safety alerts were reviewed by a senior partner and shared with appropriate staff.

Learning and improvement from safety incidents

The practice manager could not provide us with details of the incident reporting process and we did not see any evidence of how learning was regularly discussed with staff. We saw that the practice had completed reviews of significant events but learning from these was not being effectively shared with all the practice staff. Staff we spoke with were inconsistent about the procedure for recording and learning from incidents and significant events. Some staff told us that they would report any incidents or accidents to the practice manager and all staff agreed that generally no feedback or learning was provided.

The practice manager told us that they were currently reviewing and developing most of the policies at the practice and recognised that the policy for incident reporting had not yet been embedded at the practice.

Reliable safety systems and processes including safeguarding

The practice had some systems to manage and review risks to vulnerable children, young people and vulnerable adults. We saw that a practice policy for child and vulnerable adult safeguarding was available and we looked at training records which showed that all staff had received relevant role specific training in this area. However, our discussions with staff showed that the policies and procedures had not become established at the practice. For example, one member of staff we spoke with was unable to tell us about their most recent training, where the numbers to contact the safeguarding team were located should they need to make a direct referral or the practice policy for safeguarding. They also told us that safeguarding was not their responsibility as it would not be a part of their role.

Staff we spoke with were inconsistent about who they believed to be the safeguarding lead. One staff member thought it was the practice manager whilst another believed it was the GP. We spoke with the GP who was the safeguarding lead. We were told that there had not been any recent safeguarding referrals made but system existed where GPs could add an alert if they were concerned about any safeguarding issues.

Notices were visible in the clinical rooms and in reception to ensure patients were aware that they could request a chaperone to be present during their consultation. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. We were told that either the practice nurse or the health care assistant (HCA) normally undertook chaperoning duties at the practice

We were told that reception staff had on occasion chaperoned in the absence of the HCA and practice nurse. One reception staff member provided us with an example of when they had chaperoned and the procedure they had followed. We found that they had not understood where they should stand to appropriately observe the examination. We saw evidence the GPs had been checked via the Disclosure and Barring Service (DBS) but the practice was unable to demonstrate that other practice staff (including the HCA and practice nurse) had also undergone the DBS checks. A DBS check is used to 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. In the absence of these DBS checks, risk

assessments had not been carried out in its place. Since the inspection, we have received confirmation that both the HCA and the practice nurse had now undergone DBS checks.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We checked a sample of medicines and vaccines at the practice and saw that they were all in date and suitable for use.

There was a policy available for ensuring vaccines were kept at the required temperatures to ensure they maintained their effectiveness. This was being followed by staff and we saw records which confirmed that daily temperature checks were undertaken of the medicines refrigerator in which the vaccines were stored. Both the practice manager and healthcare assistant (HCA) told us that they were responsible for monitoring the fridge temperature but it was not clear that they both equally understood what to do in the event of potential cold chain failure. We were told that medicines would be disposed of if the fridge temperature was found to be out of range. We saw from the fridge temperature records that in the past six weeks the maximum temperature had been out of range on three occasions but no record of the interventions made could be found. One staff member suggested that the temperature increases could be corresponding to the days the fridge medicine stock was checked. This meant that the process for checking medicines was inadequate as it allowed the temperature of the whole fridge to increase.

Staff told us that medicines which did not require storage in the refrigerator were checked by the HCA on a monthly basis but that this was not recorded.

There were appropriate arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure medications remained relevant to their health needs. Patients were notified when their medication reviews were due. We saw evidence that showed 99% of patients requiring repeat prescriptions had a medicines review within the past 12 months.

Blank prescription forms were held securely but there was no clear audit trail of those kept at practice. The monitoring system used for managing blank prescriptions by the practice did not provide an accurate record of the expected stock.

Cleanliness and infection control

There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment (PPE) and disposable privacy curtains that were clearly dated and showed that they had been recently changed. We viewed the practice cleaning schedules and saw they were signed off on a weekly basis. We observed the premises to be visibly clean and tidy and patients we spoke with told us they had no concerns regarding the cleanliness of the practice.

The practice had recently completed a risk assessment for the management, testing and investigation of legionella (bacteria which can contaminate water systems in buildings). This had been completed by the lead GP and the assessment had concluded the practice to be low risk.

We saw that there was an infection control policy in place but it did not provide sufficient guidance to staff. Staff had been assigned different areas of infection control but staff training records we viewed showed that they had not undertaken any recent training in this area to enable them to support each other on the infection control.

We found that the healthcare assistant's (HCA) room was located upstairs where some clinical procedures took place. This room was carpeted and did not contain any washing facilities. The HCA told us that they would have to leave the room and go across the hallway to the staff sink located in a room labelled "washroom" in order to wash up. The washroom was located next to the staff toilet and this washroom sink was also being used by those using the staff toilet. This was because there were no handwashing facilities within the staff toilet. An infection control audit for March 2015 was sent by the practice post-inspection. However, this audit did not demonstrate that areas identified for improvement had been developed into an action plan or addressed by the practice. An infection rate audit for minor surgery was also seen.

Equipment

Staff we spoke with told us they had the necessary equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence from stickers on relevant equipment that they had undergone portable appliance testing (PAT) and calibration checks during April 2015.

Inadequate

Are services safe?

Staffing and recruitment

The systems in place in respect of recruitment were not safe and effective. The practice manager told us that they were currently reviewing and developing most of the policies and acknowledged that some policies had not yet been embedded at the practice. We saw that the recruitment policy was not robust and did not contain sufficient details such as the requirement for identification checks or Disclosure and Barring Service (DBS) checks where appropriate.

We asked for staff records and found that they were not well organised and information was very difficult to find. The practice manager recognised that this was an issue. We were told that a practice nurse had been appointed in November 2014. We saw that recruitment policy procedures had not been followed. We were informed that references had not been obtained.

We saw evidence that DBS checks had been completed for the GPs. However, the practice were unable to demonstrate that the rest of the practice staff had undergone either criminal records checks or risk assessments. Risk assessments would assure the provider that a DBS check was not necessary. We were informed that the healthcare assistant (HCA) and nurse had been DBS checked, however the practice were unable to provide evidence of this. Since the inspection, we have received confirmation that both the HCA and the practice nurse had now undergone DBS checks.

Staff were generally satisfied that there were enough staff to meet the needs of patients. Reception staff told us that they had set a rota to cover practice opening hours.

Monitoring safety and responding to risk

The practice did not have effective systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice told us that recent health and safety training had not taken place for any of the staff. We were told that the practice had not carried out a health and safety risk assessment with the exception of a legionella risk assessment.

A washroom where the staff sink was located was being used to as an overflow storage room for materials such as chlamydia testing kits. A worktop had been placed on top of the bath in this washroom and materials piled on top of this worktop. Patients using any of the rooms upstairs would need to walk past this room which was not kept locked.

The actual storage room was located next to the washroom and found that it was locked by a bolt near the top of the door where children could not reach to open it. However, any adult patients who had to walk past this room to get to the treatment rooms would easily be able to gain access. We also found that the staff toilet, which again both patients and staff had to walk past to get to the treatment rooms, did not lock.

A room containing the practice servers (a device which manages the computer network of an organisation) was located within the waiting area downstairs. The door to this room was kept unlocked and children could easily gain access. We asked the practice staff about this and we were told that the door was sometimes kept ajar so that the server did not overheat. We highlighted to the practice that this was unsafe as it could present a potential hazard to children who could grab hold of wires. The practice informed us that the server room door would now be locked during practice hours.

The practice did not undertake effective checks of the building and environment to identify any issues that needed to be addressed. For example, we noted that in the absence of a risk assessment, concerns such as those relating to the secure storage of supplies, children being able to access potentially harmful areas, staff recruitment procedures and infection control had not been addressed by the practice.

We saw evidence of a recent fire assessment carried out by an external company and saw that some of their recommendations had been followed such as safer storage of combustible materials. However fire alarm tests had not been taking place monthly as per practice policy and the practice confirmed that they had never carried out a fire drill. Staff had received fire training although this had taken place two years ago.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. A contract was in place to ensure the safe disposable of clinical waste.

Inadequate

Are services safe?

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

Emergency equipment was available including access to oxygen and an Automated External Defibrillator (AED) which is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. We saw evidence showing that the oxygen and AED were checked and recorded weekly by the health care assistant. When we asked, all members of staff were knew the location of this equipment. All the medicines we checked were in date and fit for use and were located in a secure area of the practice.

An emergency plan document was seen in reception and it was also possible to access this plan on the computer. We saw that the plan covered emergencies such as power failure, adverse weather, unplanned sickness and access to the building with relevant contact details for staff to refer to. One staff member we spoke with was not aware of this document but told us that they would refer to the practice manager in any emergency situation.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP we spoke with had appropriate knowledge of National Institute for Health and Care Excellence (or NICE) guidance. NICE is responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. For example, they told us about the recent changes in anticoagulant management in patients with atrial fibrillation and how diabetes care was in line with current NICE guidance.

We found that the GP undertook reviews of patients with asthma, diabetes and hypertension. The GP told us that patients are told of the timing and frequency of their reviews and patients were expected to take responsibility for this. However, the GP did also carry out appropriate searches to ensure that this had happened. Reception staff also confirmed that they received this list from the GP of patients identified as being overdue reviews and they would seek to contact patients to attend where appropriate.

We saw that 22 patients had been placed on the learning disability register of which 21 had care plans and annual reviews whilst 15 patients had been identified and placed on the mental health register and 14 of these had care plans in place. We saw evidence that the 2 patients who did not have this in place had declined the offers of reviews although they had been provided the opportunity.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP showed that the culture in the practice was that patients were cared for and treated based on need.

Management, monitoring and improving outcomes for people

The practice manager told us that they were looking at the practice's performance in relation to the quality and outcomes framework (QOF) and national screening programmes to try and identify areas for improvement. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice's overall performance against QOF data for 2013/14 was similar and in some cases better than both the CCG and the national average. For example, the percentage of patients at the practice with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented was 93% compared to the national average of 86%.

The practice manager told us that they verbally updated the rest of the practice staff on an ad hoc basis. However, staff we spoke with told us that the lack of regular practice meetings meant that they were not always informed about the practice performance. We were told that , the practice intended to ensure that regular practice meetings took place.

We were told that the practice manager and reception staff looked at lists provided by the GP on a monthly basis which identified patients for review. The practice manager told us that she would do searches on the computer system as requested by the practice nurse and healthcare assistant, to identify specifics groups of patients who required a review and had not had one. This list of patients would then be passed onto reception staff who would seek to contact the relevant patients.

We saw evidence of clinical audits completed by the GPs such as an audit of infection rate in minor surgery and an audit of consent obtained prior to minor surgery which had been completed in April 2015. No issues were found following the infection rate audit but in the case of consent, the results of the audit had led to a redesign of the consent forms. Although we did not see any audits that had undergone a complete audit cycle, we saw that the consent in minor surgery audit was due to be repeated in four months' time. Other audits we viewed related to prescribing rates. Data we had viewed from 2013/2014 had identified that the average daily prescribed quantity of hypnotics (drugs used to help someone sleep) was higher at the practice than the national average. However, the practice told us that currently the rate of prescribing was similar to practices in the local area.

The lead GP told us that all learning from audits was shared with the practice staff through monthly practice meetings and notes of these meetings were available from the practice manager. However, practice staff (including the practice manager), informed us the practice meetings did not occur regularly and the practice manager could not provide us with evidence to show that learning from the audits had been shared with any of the practice staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

We were told about a practice development plan that had been inspired by the local clinical commissioning group (CCG). The GP told us that discussions took place with other practices to look at diabetic and gynaecology care in the local area and identify areas of good practice.

Effective staffing

We found the provider did not have suitable arrangements in place to ensure that all staff received appropriate training, professional development and appraisal. Most staff we spoke with were unsure when they last had an appraisal whilst one staff member believed it may have been over two years ago. When we asked the practice manager for evidence of appraisals for the practice staff, we saw one where a staff member had last had an appraisal in 2006 whilst no information was available for any other staff member. The practice manager told us that they were hoping to start the appraisal process for all practice staff from May 2015. In the absence of recent appraisals the provider did not demonstrate how the staff were supported to deliver care safely and to suitable standards.

On the day of our inspection a locum GP was also present and the practice manager told us that they used they normally used the same locum GP when required. We saw evidence of a detailed locum pack that contained essential information for locums such as the location of the emergency drugs and equipment, the referrals forms available, relevant contact numbers, the practice panic button process and a link to the location of all practice policies. Evidence that demonstrated that the lead GP had undergone revalidation was also seen. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Training records were not managed in a way which made it easy to identify and monitor what training staff had received and whether they were up to date with attending the practice's mandatory courses. Although there were no overall records of staff training maintained our review of some of the individual staff training records confirmed these staff had received training relating to safeguarding, basic life support and confidentiality. We were told that infection control training was being organised for staff through e-learning.

Working with colleagues and other services

Blood results and other letters were accessed by the practice through their clinical system. We were told that the two GPs were responsible for checking test results and discharge letters received from hospital. If one GP was on leave, there was a system in place to provide cover by the other GP.

The lead GP told us that either they or the salaried GP reviewed details of the out-of-hours reports on a daily basis before the start of morning surgery. If action was required following this review, the patient was contacted by the GP. Notes containing details of health issues, medication and progress were also shared with the out-of-hours provider for patients with complex health needs.

We were told the practice held quarterly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by the practice manager, GPs, district nurses and a representative from MacMillan cancer support. Although the practice manager could not provide any notes of these meetings, we were told that the medical records of the appropriate patients were updated at the time of the discussions. We viewed examples of clinical notes entered at the time of these meetings.

A midwife was hosted at the practice on a weekly basis and although a health visitor did not attend the practice, contact could be made with a named health visitor at a local clinic.

Information sharing

The practice told us they used electronic systems to communicate with other providers such as local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Any significant changes to patient medical notes following multidisciplinary team meetings were also shared by the practice with the out-of-hours service.

The senior GP told us they did not use the choose and book system very frequently. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Consent to care and treatment

We viewed evidence that showed the lead GP had completed training in the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for acting and making

Requires improvement

Are services effective?

(for example, treatment is effective)

decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The GP also discussed an example where consent for treatment had been obtained for a patient with significant learning disabilities that was in line with the recommendations of the MCA.

We reviewed an audit on minor surgery that had been carried out in April 2015 which reviewed patient consent obtained prior to the minor surgery. The audit found that although verbal consent had been recorded in patient notes in every case, there were no records of any written patient consent before minor surgery had been carried out. In response to this, the practice had redesigned their consent forms and the audit was due to be repeated in 4 months' time.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse or healthcare assistant to all new patients registering with the practice. The GP was informed of any health concerns detected and these were followed up in a timely way.

We were told that carers were identified during the registration process and this information was coded in the clinical system. However, this information was not used to maintain a carer's register so that the practice could help them to obtain support. Carer support information leaflets were also not available at the practice. We were told that the practice did not have a bereavement policy in place but patients could ask for a leaflet on bereavement from reception.

The practice had identified some patients who needed additional support through the use of patient registers. We saw evidence that patients such as those with a learning disability or poor mental health were offered and received annual health checks. These patients also had care plans in place.

We found that the practice was performing above the clinical commissioning group average (CCG) for flu vaccinations of patients over 65 years and in line with the national average.

The practice offered a range of health promotion and screening services. This included child immunisations, flu vaccinations and cervical screening, weight management and smoking cessation. The practice's performance in these areas was mostly near or slightly above the national average. For example, the percentage of children age 12 months registered at the practice who had received the relevant vaccinations was between 97-100% whilst the local area average was between 83-96%. A midwife attended the practice on a weekly basis and offered antenatal sessions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and the majority were positive about the service experienced. Patients commented they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five of the comment cards also mentioned that the premises could be improved especially the waiting area which patients noted as being too small with insufficient seating.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to maintain patient confidentiality. The reception area was shielded by glass partitions which helped keep confidential patient phone calls private. Reception staff told us that if a patient wished to speak with them in private they would use a spare consulting room. We saw signs in the waiting area alerting patients to this.

There was one female GP employed at the practice in addition to the main male partner which gave patients the option of seeing either a male or female GP.

Care planning and involvement in decisions about care and treatment

The national GP patient survey from January 2015 indicated that 85% of patients said the last GP they saw or spoke to was good at explaining tests and treatments. This was near the Clinical Commissioning Group (CCG) area average of 86%. Also, 77% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. This was below the CCG area average of 80%.

We saw evidence that care plans were in place for patients experiencing poor mental health and those with learning difficulties. All had been offered and had attended an annual health check with only one patient from each of these two groups declining one.

Patient/carer support to cope emotionally with care and treatment

There was limited evidence to show that the practice was proactively providing patient and carer support to cope emotionally with care or treatment. The practice also did not have any arrangements in place to make contact patients who had suffered bereavement although we were told this information was recorded on their patient notes. The GP told us they would recommend and signpost relevant patients to local services such as the Solihull Bereavement Counselling service when the opportunity arose.

We were told by the GP that information leaflets on bereavement support were available in the waiting rooms area for patients as well as information for carer support services. We did not see either of these leaflets available to patients in the waiting area and reception staff we spoke with confirmed that a bereavement support leaflet that was kept behind the reception desk. This was not a very robust system that took into account patient sensitivities as it meant patients would have to approach reception staff for a leaflet after being made aware one was available. Carer support information leaflets were not available. However, the practice maintained a carer's register so that they could help them to obtain appropriate support if required. The GP patient survey we looked at showed that 98% of respondents stated that the last nurse they saw or spoke to was good at treating them with care and concern whilst the national average was 90%. For GPs 85% of respondents stated that the last GP they saw or spoke to at the practice was good at explaining tests and treatments. This was the same as the national average.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We spoke with staff about how they supported different groups in the community to access care and treatment and reduce potential barriers. The practice held a register for patients with learning disabilities and poor mental health and we saw that annual health reviews had been undertaken. Staff told us that they had not had anyone try to register with no fixed abode or asylum seekers but would refer to the practice manager for advice. The practice manager told us that although there was no practice policy regarding this, they would try and accommodate such patients where possible.

The lead GP chaired the Solihull Local Medical Committee which represents GPs and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss local priorities. We saw that the practice were aware of the health inequalities that existed within the local area and had been working to reduce these. For example, we saw that the practice was actively engaged in promoting smoking cessation.

The practice had a patient participation group (PPG). A PPG is a way in which the practice and patients can work together to help improve the quality of the service. We were told that there were currently only three members of this group. A link to join the PPG was available on the practice website which had been in place for a number of years. The practice manager told us that they found it very challenging to get patients to join the PPG but could not provide us with evidence to demonstrate any other ways they had considered to improve this situation.

There were no PPG meeting notes available but we were able to view the PPG annual report dated March 2015. We saw from this report that the results of an annual patient survey had been analysed and shared with the PPG for their input. From this the PPG had developed a list of actions for 2016 which had been agreed with the practice. For example, we saw that one of the actions for next year included further development of the online appointments booking and repeat prescriptions systems.

The GP told us that patients who were referred by the practice to hospital were provided with a medical history summary to take with them. This included things such as the patient's current medications, health issues and any allergies.

Tackling inequity and promoting equality

We saw that the entrance to the practice had a ramp access with a handrail which aided those with mobility issues. A disabled toilet was also located on the ground floor. However, the reception desk did not have a low level area which would enable patients who required the use of a wheelchair to speak with staff easily. Staff we spoke with told us that they would come out of the reception area to speak with patients who were wheelchair users. There was also an induction loop system in place to help patients who used hearing aids.

The practice was located on two floors which meant that patients with mobility issues could not access the upstairs rooms. We were told that such patients would be offered appointments in the one consulting room located on the ground floor. One patient comment we received stated that more of the rooms needed to be located on the ground floor as both the healthcare assistant and nurse's rooms were located upstairs. However, we saw that the layout of the premises restricted this from being possible.

We observed that the patient waiting area was small although on the day of our inspection, we noted that it was sufficient for the patients attending. However, patient feedback we received highlighted the lack of space in the waiting area which could become very full. Patients also commented that there was insufficient seating in the waiting area especially during morning appointments. One patient commented that the practice premises were too small in general.

We were told that all patients registered with the practice spoke English which meant that interpreting services were not needed. However, should interpreting services be required in the future, staff were not aware of the arrangements which would allow access to translation services.

Access to the service

The practice was open between the hours of 8am to 6pm on Monday, Tuesday, Thursday and Friday. The practice

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

closed on Wednesday afternoon from 12.30pm. Although the practice reception area closed for only an hour each day, the practice reception phone lines remained closed from 12.30pm and 4pm daily.

Badger, an out-of-hours (OOH) provider delivered the OOH service when the practice was closed. Badger also provided a service during the day time when the surgery's reception phone lines were closed. However, the answerphone message set-up did not change depending on the circumstances and the time of day. For example, when the reception phone lines closed for three and half hours during the practice opening hours, the answerphone message did not let the caller know that the phone lines would reopen again later in the day. Staff we spoke with about this told us they realised this could cause patients confusion but they had not been able to work out how to add an additional message to the answerphone system. This meant that patients calling the practice would not always realise that the phone lines would re-open.

The practice offered open access walk-in appointments in the mornings and booked appointments were available in the afternoons from 4pm to 6pm. These could be booked for the same day or up to two weeks in advance. The national patient survey for January 2015 reported that 87% of patients at the practice stated that it was easy to get through to someone at GP surgery on the phone compared to 71% nationally. Staff told us appointments and repeat prescriptions could also be booked online. This had only been introduced by the practice three months ago and uptake had been very low. However, we saw that posters had been placed in the waiting area alerting patients to this new online facility.

Listening and learning from concerns and complaints

The practice was unable to demonstrate that the system for handling complaints was robust as they had not received any complaints in the last 15 months. The practice showed us a complaints leaflet that was available from reception. We were told that patients would have to specifically request a copy from reception staff. However, we did not see any evidence of posters alerting patients to this in the waiting area. Patients we spoke with were unaware of the process to follow if they wished to make a complaint. One patient we spoke with told us they would feel uncomfortable asking the reception staff for a complaints leaflet and would prefer if the leaflets were available in the waiting area to pick up.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

We found that the provider had considered the future direction of the practice in light of a further increase of patients wishing to join the practice and future partnerships. However, this had not been communicated with staff who were unable to express the vision or strategy of the practice. We spoke to the practice manager about the future direction and development of the practice but they were unable to articulate or provide us with evidence of a clear strategy. We did not see notes of any discussions at meetings where the staff had discussed and agreed any visions or values of the practice.

We discussed with the GP about how the practice planned to deliver care with the future challenges that faced them such as access to the service and resources. We were told that when a local practice had closed down in 2011, the practice had to suddenly accommodate an additional 1200 new patients. This rapid increase in patient list size had caused significant pressure on practice resources especially in light of the size of the premises.

The lead GP also told us of their concern that another impending surge in patient list size was probable with the potential closure of another local practice. We were told that due to the high possibility of this local practice closing down, 200 patients who had been registered with that local practice had already joined them within the last 18 months. We were told that due to the size of the premises, there was limited scope for expansion of the practice and the increase in patients already had caused considerable strain on current resources. Due to this no formal plans or strategies had been developed to accommodate further increases in patient list size.

Governance arrangements

We saw a number of policies and procedures on the computer system at different stages of development and review with a number of newly acquired policies and procedures at the practice to govern activity, but these had not yet become established as the practice was in the process of undertaking a review of all policies. There were no systems in place to monitor whether staff had read a policy and when. Staff we spoke did not demonstrate consistent knowledge of practice policies. The practice manager told us that they were currently reviewing all the policies and were in the process of starting to embed them in the practice.

We found that staff had become very isolated in their roles and some were not clear about their own roles and responsibilities. For example one staff member we spoke with told us that although they knew that policies existed, reading these was not something that would help them in their role and were the responsibility of the practice manager. We were told that they would refer to the practice manager if they were unsure about any practice procedure.

Staff were inconsistent about the frequency of staff meetings with one member of staff telling us that they had never attended a practice meeting. The practice manager told us that staff meetings would take place on an “ad hoc” basis and that notes would be taken. However, the practice could not provide any evidence of the notes taken or the meeting agenda. A GP told us that the GPs and practice manager had daily meetings, which were not minuted. We spoke with staff about the last practice meeting that took place and what was discussed. We found staff could not provide us with any details about when the practice meeting had taken place or what had been discussed. The lack of regular practice meetings also meant that there was no main forum for discussing governance issues or to embed newly reviewed practice policies.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance and we were told that the GP and practice manager regularly looked at the QOF data. The QOF data for this practice showed it was performing in line with national standards.

We were told that the GPs held monthly meetings with the Clinical Commissioning Group (CCG) to discuss comparative referral and prescribing data and any information was circulated to the practice clinical staff in an informal way. Post-inspection the GP provided us with examples of some improvements and changes that had taken place such as prescribing savings and use of new computer software.

Leadership, openness and transparency

Staff told us that as a small practice and they discussed issues informally rather than through formal meetings. However, staff we spoke with were not consistently aware of the practice policies, issues and updates.

Are services well-led?

Inadequate

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

The practice staff did not have a clear understanding of the processes and protocols to use in certain situations (for example managing poor performance and appraisal). We reviewed some policies as well as other documents such as staff files. The files were not well organised and policies and other documentation was found to be missing from personnel files.

The GP told us they had an open door policy. Staff told us that management were fairly approachable but there were no formal routes to providing feedback or to challenge and debate issues.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a patient participation group (PPG). A PPG is a way in which the practice and patients can work together to help improve the quality of the service. We were told that there were currently only three members of this group. A link to join the PPG was available on the practice website. The practice manager told us that they found it very challenging to get patients to join the PPG but could not provide us with evidence to demonstrate they had considered what they could do to improve this situation.

There were no PPG meeting notes available but we were able to view the PPG annual report dated March 2015. We saw from this report that the results of an annual patient survey had been analysed and shared with the PPG for their input. From this the PPG had developed a list of actions for 2016 which had been agreed with the practice. For example, we saw that one of the actions for next year included further development of the online appointments booking and repeat prescriptions systems.

The practice told us that no complaints had been received by the practice for at least the last 15 months. We saw that the complaints procedure at the practice was not one that invited patients to raise any issues or concerns easily. A patient suggestions box was located on the reception desk which was empty on the day of the inspection. Staff we spoke with confirmed they had never received a suggestion. We found that no systems were in place to gather staff feedback although staff told us that they were able to have informal discussions.

Management lead through learning and improvement

We saw evidence that showed both the practice GPs had annual appraisals and undertook continuing professional development. However, we found that no other staff member had recent annual appraisals and we were only able to view one appraisal that had taken place in 2006.

The practice manager told us that they were planning on re-starting annual appraisals very soon. In the absence of recent appraisals we were not clear how the staff were supported to deliver care safely and to suitable standards or demonstrate that individual performance and training needs had been considered and discussed.

There were no systems in place to monitor staff training and development. We were told that the practice nurse was being supervised by the GP. Post-inspection we were provided with continuing professional development (CPD) certificate evidence of the training that had been completed by the practice nurse and healthcare assistant.

The practice had completed reviews of significant events but learning from these was not being effectively shared with all the practice 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 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems in place to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk (for example by having robust systems in respect of complaints, incidents, accidents, health and safety risk assessments).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported to receive appropriate professional development or appraisals.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not operate effective recruitment procedures to ensure they obtained all of the information and documentation required by law before people started working at the practice to ensure they were suitable to work with patients.**