Norvic Family Practice

Inspection report

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Date of inspection visit: 6 June 2018
Date of publication: 03/08/2018

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.

Overall summary

We carried out an announced comprehensive inspection at Norvic Family Practice on 16 January 2018. The overall rating for the practice was Inadequate. Breaches of legal requirements were found and after the comprehensive inspection we issued the following warning notices:

• A warning notice informing the practice that they were failing to comply with relevant requirements of the Health and Social Care Act 2008. As a result, the practice were required to become compliant with specific areas of Regulation 12: Safe care and treatment HSCA (RA) Regulations 2014, by 17 May 2018.

• A warning notice informing the practice that they were failing to comply with relevant requirements of the Health and Social Care Act 2008. As a result, the practice were required to become compliant with specific areas of Regulation 17: Good governance HSCA (RA) Regulations 2014, by 17 May 2018.

The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Norvic Family Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 6 June 2018, at the main site Norvic Family Practice, 5 Suffrage Street, Smethwick, West Midlands, B66 3PZ . This was to confirm that the practice had carried out their plan to meet the legal requirements in relation to the warning notices issued. This report only covers our findings in relation to those requirements. We did not visit the branch practice site as part of this inspection, which is located at Norman Road Surgery, 110 Norman Road, Smethwick, West Midlands B67 5PU. However, we followed up actions and reviewed evidence which related to the branch practice and referred to this in the warning notice.

Our key findings were as follows:

• There were a number of policies and procedures to govern activity however, some lacked detail and were not followed consistently. Disclosure and barring check (DBS) were not carried out in line with the practice policy for checks. The recruitment policy lacked detail on the pre-employment checks required.

• The practice had made positive changes to ensure reliable systems were in place for the appropriate and safe use of medicines. This included the monitoring of patients in receipt of high risk medicines.

• There were risk assessments in relation to safety issues. This included fire safety and infection prevention and control.

• The system for recording and learning from significant events was not clear or consistent to support learning and improvements.

• The practice acted on and learned from national safety alerts such as alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Staff were able to demonstrate that they had taken necessary action in response to specific safety alerts.

• The practice had made some improvement to the governance processes. However, there was a lack of oversight in some areas such as recruitment files and significant events.

The areas where the provider must make improvements are:

• Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a second CQC inspector.

Background to Norvic Family Practice

Norvic Family Practice is located in Smethwick, a town in Sandwell in the West Midlands. It is four miles west of Birmingham city centre and borders West Bromwich to the north and Oldbury to the west.

There is access to the practice by public transport from surrounding areas. There are parking facilities on site.

The practice holds a General Medical Services (GMS) contract with NHS England. The GMS contract allows the practice to deliver primary care services to the local communities. The practice currently has an approximate list size of 9,150 patients. The practice provides GP services commissioned by NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice is situated in an area with high levels of deprivation with a score of level one. Level one represents the most deprived areas and level 10, the least deprived. The age distribution of the practice population broadly follows that of the national average.

The main site is based at 5 Suffrage Street, Smethwick, West Midlands, B66 3PZ and operates from a purpose built premises. Patient services are available on the ground level of the building. The premises is also shared with another GP practice and other healthcare professionals including district nurses, health visiting teams, physiotherapy and chiropody specialists. The practice has a branch site located at Norman Road Surgery, 110 Norman Road, Smethwick, West Midlands B67 5PU.

The practice is currently managed by three GP partners (one male, two female). The partners also employ a salaried GP. They are supported by one practice nurse, one healthcare assistant, a practice manager and a team of administrative and clerical staff.

The practice is a training practice for GP trainees. One of the GP partners is a GP educational supervisor for two trainees. At the time of our inspection, the practice did not have any trainees assigned to the practice.

The main practice site is open from 8am to 8pm Monday to Friday. Saturday opening is from 9am to 11.30am and Sunday opening is from 9am to 11am.

Are services safe?

At our previous inspection on 16 January 2018, we rated the practice as inadequate for providing safe services and issued a warning notice. Patients were at risk of harm because systems and processes were not in place to keep them safe. This included the management of medicines and lack of risk assessments.

These arrangements had improved in some areas when we undertook a follow up inspection on 6 June 2018. However, there were still areas which required further improvement.

• During this inspection, staff files we looked at remained incomplete and did not contain all of the relevant recruitment information as set out in the practice recruitment policy. We looked at four personnel files including a member of the clinical team employed since our previous inspection. We saw gaps in the recruitment checks carried out for some staff and the required information was not consistent with the practices recruitment policy. The necessary information was not organised or easily accessible on the day. However, following our inspection, the practice provided evidence of recruitment checks carried out in line with their recruitment policy

• Although staff who acted as chaperones had received a standard disclosure and barring check; an enhanced check which included a check of the barred list for children and vulnerable adults had not been carried out. (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).

• Actions from the infection prevention and control (IPC) audit undertaken at the main site in July 2016 were now complete. A further IPC audit had been undertaken at the main site in January 2018 and areas identified for improvement had been actioned.

Appropriate and safe use of medicines

The practice had reliable systems in place for the appropriate and safe use of medicines.

• There was an effective recall system to ensure medication reviews were carried out as part of, and aligned with, patients care and treatment plans. This included patients in receipt of a high risk medications which required closer monitoring, patients with long term conditions, patients on repeat medications and those prescribed a number of medications concurrently. Patients were involved in regular reviews of their medicines.

• Staff had the appropriate authorisations in place to administer medicines as part of Patient Group Directions (PGDs) and Patient Specific Directions (PSDs). PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PSDs are written instructions by a prescriber, for medicines to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.

• Prescription stationery was kept securely and monitored to provide a clear audit trail.

Track record on safety

The practice had completed a range of risk assessments to ensure risks were identified and managed.

• The practice had not completed a general health and safety risk assessment that covered all areas of the branch practice. However, individual risks had been assessed and actions taken because of findings such as lone working.

• The local fire officer had inspected the branch practice and provided advice and guidance. The practice had completed a risk assessment and acted on areas for improvement identified. Testing of fire equipment had been completed by an external contractor.

• The practice had completed risk assessments for the control of substances hazardous to health (COSHH) and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

• A building folder was located in the reception area at the main practice site to ensure important information was accessible to staff. Meetings were taking place with NHS Property Services which provided the opportunity for the practice and other services based in the building to raise issues.

Lessons learned and improvements made

The practice had made improvements to the system and process for acting on patients safety alerts. However, the system for recording and sharing significant events was inconsistent.

Are services safe?

• The practice had a combination of paper based and electronic systems for recording and monitoring significant events. We looked at two incidents recorded on the electronic system and saw gaps in the information recorded for each incident such as details of the learning outcome. The manager told us that the relevant information was stored in a folder at the branch practice and they referred to the folder more than the electronic system. There was also a lack of evidence to demonstrate learning and dissemination of information from significant events. This did not provide assurance that the practice had a clear consistent system for recording and learning from significant events which posed the risk of missed themes and trends to reduce the likelihood of reoccurrence.

• The practice acted on patient safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Evidence reviewed showed that the practice had taken necessary action in response to MHRA alerts. The practice also completed audits on patients safety which demonstrated a proactive approach.

Please refer to the Evidence Tables for further information.

Are services well-led?

At our previous inspection on 16 January 2018, we rated the practice as inadequate for providing well-led services and issued a warning notice. The governance framework did not support the delivery of good quality care and enable the practice to identify and monitor risks. This was reflected by a lack of robust system and processes in areas such as recruitment, infection prevention and control, medicine management, fire safety, significant events and patients safety alerts.

At this inspection significant improvements had been made in some areas. However, there remains areas for improvement. This included the ongoing development of effective management structures, processes and systems to support good governance and to ensure the delivery of a high quality, safe and sustainable service.

Leadership capacity and capability

• The GP partners at the practice had understood some of the challenges and were addressing them. This was demonstrated in the improvements made to the systems in place for the appropriate and safe use of medicines.

• The practice did not have effective processes to support and develop management capacity and skills as not all areas for improvements identified at the previous inspection had been fully addressed.

Governance arrangements

The practice had made some improvement to the governance processes. However, there were areas that lacked oversight and the systems and processes required strengthening such as recruitment.

• Structures, processes and systems to support good governance were in place however, these required further development to be fully effective.

• Practice leaders had established policies and procedures to ensure safety. This included reviewing and updating policies such as fire, legionella and incident reporting. However, we saw that policies were not always followed such as with DBS checks.

Managing risks, issues and performance

The practice had made improvements to processes for managing risks.

• There were arrangements for identifying, recording and managing risks such as health and safety, fire and infection prevention and control. The practice had reliable systems in place for the appropriate and safe use of medicines.

• Practice leaders had oversight of national and local safety alerts and acted on them accordingly.

• There was a process for recording and sharing learning from incidents and significant events however, this required improvement.

Please refer to the Evidence Tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is 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 Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met. There were a lack of effective systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • A lack of risk assessment for a staff member that acted as chaperones in the absence of a DBS check at the appropriate level for their role and with a disclosure recorded on their check. There was a lack of risk assessment for a newly appointed member of staff who had a DBS check from a previous employer. •The practice had not completed a general health and safety risk assessment that covered all areas of the branch practice. •There was also a lack of evidence to demonstrate learning and dissemination of information from significant events. We noted inconsistencies in the system for recording and learning from significant events which posed the risk of missed themes and trends to reduce the likelihood of reoccurrence. There were a lack of effective systems or processes that ensured the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular: • Personnel files looked at were incomplete and did not contain relevant information in regard to recruitment.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17 (1) (2)