Lockfield Surgery

Quality Report

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

Ratings

Are services safe?	**Inadequate**
Are services well-led?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Lockfield Surgery, with a visit to the branch site, Raynor Road Surgery, on 12 May 2015. Breaches of legal requirements were found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We undertook a responsive inspection on 28 April 2016 to ensure the practice had taken the appropriate action in relation to Regulation 12.

This report covers our findings in relation to the responsive inspection, where we were required to follow up on the safe and well led domains only. As this was a focused inspection the ratings for the remaining domains and population groups are unchanged following the earlier inspection on 12 May 2015.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lockfield Surgery on our website at www.cqc.org.uk.

During our inspection on 12 May 2015 we found that the practice had identified that the branch site at Raynor Road was not a suitable premises to deliver care and treatment and we saw plans in place to relocate during July 2015. However, as part of our focused inspection approach we found that the practice had not been able to relocate their branch surgery as planned. We therefore visited the Raynor Road branch surgery as part of this inspection.

During our inspection on 28 April 2016 we identified significant concerns with regards to the premises used for the branch surgery at Raynor Road. In order to keep patients and staff safe, the Care Quality Commission imposed an urgent condition to prevent the delivery of regulated activities from the branch surgery; this condition came in to effect from 1pm on 5 May 2016.

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

- We identified a number of significant concerns with regards to the premises used for the branch surgery at Raynor Road. The premises were unsuitable for people with mobility problems, for wheelchair users and for

Summary of findings

people with prams and pushchairs. Overall, the branch surgery required extensive maintenance and repair work; it was visibly cluttered in areas and appeared to be neglected.

- Patients were not being protected against the risk of unsafe care and treatment as a result of inadequate infection control at Raynor Road surgery.
- There were inadequate arrangements for managing emergency medicines and vaccinations across the practice.
- At Lockfield surgery there were some procedures in place for monitoring and managing risks to patients' and staff safety. These included formal risk assessments to monitor safety of the premises including health, safety and fire risk. However, there were no procedures in place for monitoring and managing risks to patients and staff safety at Raynor Road surgery.
- Recorded significant events, incidents and complaints were discussed during monthly practice meetings to monitor actions and share learning. However, the systems to monitor safety were not embedded well enough across both practice locations.
- Although staff spoke positively about working at the practice, we found that some staff were unclear regarding the status of the plans to relocate the branch surgery at Raynor Road.

The areas where the provider must make improvements are:

During our inspection on 28 April 2016 we identified significant concerns with regards to the premises used for the branch surgery at Raynor Road. In order to keep patients and staff safe, the Care Quality Commission imposed an urgent condition to prevent the delivery of regulated activities from the branch surgery; this condition came in to effect from 1pm on 5 May 2016.

- The provider must ensure that they continue to comply with this arrangement.
- The provider must ensure adequate arrangements are in place for managing and mitigating the risk in the absence of emergency medicines.
- The provider must ensure that all the vaccination fridges temperatures are consistently recorded, in line with guidance by Public Health England.

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.

- Whilst there were some systems in place to monitor safety, we found that these systems were not embedded well enough across both practice locations. We found that risks to patients and staff at Raynor Road branch surgery were not always identified and managed effectively to mitigate risk.
- Recorded significant events, incidents and complaints were discussed during monthly practice meetings to monitor actions and share learning.
- We identified a number of significant concerns with regards to the premises used for the branch surgery at Raynor Road. On observing the branch surgery we could see that the building required extensive maintenance and repair work. The premises were unsuitable for people with mobility problems, for wheelchair users and for people with prams and pushchairs. Overall, the branch surgery was visibly cluttered in areas and appeared to be neglected.
- We also found that patients were not being protected against the risk of unsafe care and treatment as a result of inadequate infection control at Raynor Road surgery.
- We found that across the practice there were gaps in the arrangements for managing emergency medicines and vaccinations. We found that staff had not assessed the risk in the absence of various emergency medicines and at both Lockfield surgery and Raynor Road surgery, there were gaps in the records for monitoring the cold chain.
- At Lockfield surgery there were some procedures in place for monitoring and managing risks to patients' and staff safety. These included formal risk assessments to monitor safety of the premises including health, safety and fire risk. There were records in place to show that regular fire alarm tests and fire drills had taken place at Lockfield surgery.
- There were no procedures in place for monitoring and managing risks to patients and staff safety at Raynor Road surgery. Risks associated with Health and Safety at the branch surgery had not been formally assessed or mitigated. There were no fire risk assessments in place and the fire alarm was not tested on a regular basis. We were unable to establish where the fire alarm was at Raynor Road surgery; staff were

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unable to locate the alarm in addition to the control panel to test if the fire alarm was working. Risk had not been assessed in terms of DDA compliance; to assess compliance with the Disability Discrimination Act (DDA).

Are services well-led?

Requires improvement

- The practice had some policies and protocols in place which were accessible to staff. However, overall we found that governance arrangements were not robust.
- We identified a number of gaps in the arrangements for identifying, recording and managing risks.
- There were gaps in the records for monitoring the cold chain at both Lockfield surgery and the branch surgery.
- Although staff spoke positively about working at the practice, we found that some staff were unclear regarding the status of the plans to relocate the branch surgery at Raynor Road.

Summary of findings

The six population groups and what we found

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

Summary of findings

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

During our inspection on 28 April 2016 we identified significant concerns with regards to the premises used for the branch surgery at Raynor Road. In order to keep patients and staff safe, the Care Quality Commission imposed an urgent condition to prevent the delivery of regulated activities from the branch surgery; this condition came in to effect from 1pm on 5 May 2016.

- The provider must ensure that they continue to comply with this arrangement.
- The provider must ensure adequate arrangements are in place for managing and mitigating the risk in the absence of emergency medicines.
- The provider must ensure that all the vaccination fridges temperatures are consistently recorded, in line with guidance by Public Health England.

Lockfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Lockfield Surgery

Lockfield Surgery is situated in the Willenhall area of Walsall. There are approximately 13,200 patients of various ages registered and cared for at the practice. Patients, systems and staff operate across two surgery sites, Lockfield and Raynor Road Surgery. The practice is a two partner training practice encompassing trainee doctors. During our inspection there no GPs in training at the practice. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The clinical team consists of male and female GPs including two GP partners, two salaried GPs, a long term locum GP. There are five practice nurses and two health care assistants. The lead GP and the practice manager form the practice management team and they are supported by a team who cover reception, secretarial and administration roles.

Lockfield surgery is open between 8am and 6:30pm on weekdays except for Wednesdays when the surgery closes for half day at 1pm. Extended hours are offered once a month on Saturdays between 8am and 11am. There are also arrangements to ensure patients received urgent medical assistance when the practice is closed during the out-of-hours period.

Lockfield Surgery had a branch surgery called Raynor Road Surgery which is situated approximately four miles away in Wolverhampton. We visited both sites during our inspection. Due to significant concerns regarding the premises and the associated risk with the branch surgery, the Care Quality Commission imposed an urgent condition to stop seeing patients at the branch surgery; this condition was urgently imposed in order keep patients and staff safe.

Why we carried out this inspection

We undertook an announced focused inspection of Lockfield Surgery, on 28 April 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice had been made, after our comprehensive inspection on 12 May 2015.

We inspected the practice against two of the five questions we ask about services. We looked in to the safety of the service and due to concerns identified at the branch surgery and some ongoing regulatory breaches we also focussed on how a well-led service was being provided. This is because the service was not meeting some legal requirements.

How we carried out this inspection

The inspection team:-

Detailed findings

- Reviewed information available to us from other organisations such as NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced focussed inspection on 28 April 2016.
- Spoke with staff and observed the premises.
- Reviewed the practice's governance arrangements and methods for assessing risk to patients and staff.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice had some systems in place to monitor safety however we found that these systems were not embedded well enough across both practice locations. For example, whilst we saw records to demonstrate that risks at Lockfield surgery were identified and managed to improve patient safety, we found that risks to patients and staff at Raynor Road branch surgery were not always identified and managed effectively to mitigate risk. For example, during our visit to Raynor Road surgery we saw an exposed electrical wire on the outside wall next to the entrance used for people with mobility difficulties and wheelchair users. We discussed this with staff during our inspection and staff explained that they were not aware of the exposed wire. Therefore, the risk of this being potentially unsafe had not been identified, recorded and appropriately managed.

Recorded significant events, incidents and complaints were discussed during monthly practice meetings at Lockfield surgery, staff at Raynor Road surgery confirmed that they also attended these meetings and we saw minutes of meetings to reflect staff attendance for various areas of the practice.

The practice had a summary which highlighted that 11 significant events had occurred during the last 12 months. We looked at three significant event records and found that records were detailed and comprehensive. We saw that specific actions were applied along with learning outcomes to improve safety. For example, a significant event was recorded in relation to a delay in sending test results to a patient; this occurred due to an error being made on the practices IT system. On identifying the error, remedial action was taken and staff were reminded about the importance of carefully checking patient's demographic details. We saw that this was documented as discussed at a practice meeting with the team shortly after the event occurred to share learning on a wider scale.

Overview of safety systems and processes

We observed the premises at Lockfield surgery to be visibly clean and tidy, we identified some minor maintenance issues at Lockfield surgery with regards to some lighting which needed repairing; staff assured us that they would make arrangements for the repairs to take place. We found that the premises for Lockfield surgery were suitable for people with mobility problems, for wheelchair users and for people with prams and pushchairs. However, during our inspection we noticed that although there was a lower level reception desk for wheelchair users, this was obstructed by items such as plants. We fed this back to staff on the day of our inspection, staff assured us that the desk would be cleared to allow space for those who wished to approach the desk.

We identified a number of significant concerns with regards to the premises used for the branch surgery at Raynor Road. For example:

- On observing Raynor Road surgery we could see that the building required extensive maintenance and repair work. Many of the floor tiles in the corridors to which patients had access were cracked and had pieces missing from them. Carpets, such as those in the offices upstairs were extremely worn and lifting from the floor. Overall, the surgery was visibly cluttered in areas and appeared to be neglected.
- We found that the premises for Raynor Road surgery were unsuitable for people with mobility problems, for wheelchair users and for people with prams and pushchairs. For example, there was a step down in to the waiting room, a step down in to one of the consulting rooms and doorways throughout the surgery were narrow.

We also found that patients were not being protected against the risk of unsafe care and treatment as a result of inadequate infection control at Raynor Road surgery. For example:

- Carpets were seen to be old, stained and unclean. The laminate style flooring in one of the treatment rooms was also ripped.
- The patient and disabled toilet was not ventilated and we saw deep cracks in the wall of the toilet exposing the plaster work within the wall.

We found that across the practice there were gaps in the arrangements for managing emergency medicines and vaccinations. For example:

- We found that staff had not assessed the risk in the absence of emergency medicines at Raynor Road surgery including those used for suspected bacterial meningitis, acute severe asthma, severe or recurrent anaphylaxis and medicines used in the event of a

patient experiencing an epileptic fit. Additionally, we found that at Lockfield surgery risk had not been assessed in the absence of a specific emergency medicine associated with the procedure of fitting birth control devices.

- At both Lockfield surgery and Raynor Road surgery, there were gaps in the records for monitoring the cold chain. We found that temperatures for the vaccination fridges were not always recorded daily in line with guidance by Public Health England. We saw that fridge temperatures were not recorded as required on occasions during February, March and April 2016.

Monitoring risks to patients

At Lockfield surgery there were some procedures in place for monitoring and managing risks to patients' and staff safety. These included formal risk assessments to monitor safety of the premises including health, safety and fire risk. There were records in place to show that regular fire alarm tests and fire drills had taken place at Lockfield surgery.

However, we found that there were no procedures in place for monitoring and managing risks to patients and staff safety at Raynor Road surgery. For example:

- Risks associated with Health and Safety at Raynor Road surgery had not been formally assessed or mitigated. We found areas of uneven flooring due to cracked tiles, lifting carpets and lack of maintenance at Raynor Road surgery. In addition to this, the risk of falls had not been adequately assessed and sufficient mitigating actions had not been taken. We also found that the uneven flooring was not clearly marked to alert patients and visitors of the potential hazards.
- We saw that the most recent fire maintenance checks were completed for Raynor Road surgery in March 2015. However, there were no fire risk assessments in place and the fire alarm was not tested on a regular basis. There were no fire doors in the practice, there were bars on the windows in the upstairs offices and patient toilet, and we also saw that chairs were positioned along the wall next to the entrance at the back of the surgery which was used for wheelchair access and also as a fire exit. Staff we spoke with said they had completed one fire drill in 2015 but at the time they didn't check the fire alarm and were unable to identify where the control panel was to test the fire alarm. We were also unable to establish where the fire alarm was. During our inspection staff were unable to identify where the fire alarm was, in addition to the control panel to test if the fire alarm was working. Staff explained that a fire inspection was due to take place at Raynor Road by an external organisation in March 2016 and that this had been put on hold due to the failure to relocate the branch surgery. We did not see records to demonstrate this.
- We found that Raynor Road surgery was not suitable for people with mobility problems, for wheelchair users and for people with prams and pushchairs. Additionally, risk had not been assessed in terms of DDA compliance; to assess compliance with the Disability Discrimination Act (DDA).
- There were no records in place to demonstrate that infection control had been monitored at Raynor Road surgery and that associated risks had been assessed. Staff explained that due to the unexpected failures to relocate the branch surgery, no infection control audit had taken place within the last 12 months.

Are services well-led?

Requires improvement

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

Our findings

Governance arrangements

The practice had some policies and protocols in place which were accessible to staff. However, overall we found that governance arrangements were not robust, for example we identified a number of gaps in the arrangements for identifying, recording and managing risks.

- Risks to patients and staff at Raynor Road branch surgery were not always identified and managed effectively to mitigate risk.
- We found that staff had not assessed the risk in the absence of various emergency medicines and at both Lockfield surgery and Raynor Road branch surgery.
- At both Lockfield surgery and Raynor Road branch surgery, there were gaps in the records for monitoring the cold chain. This was also identified during our comprehensive inspection on 12 May 2015 and during our focussed inspection on 28 April 2016, we found that temperatures for the vaccination fridges were not always recorded daily in line with guidance by Public Health England.

Leadership, openness and transparency

The lead GP and the practice manager formed the management team at the practice. Staff explained that there was a regular programme of staff meetings where meetings took place every month and we saw examples of minutes to support this.

As part of our focused inspection approach we found that the practice had not been able to relocate their branch surgery as discussed during our comprehensive inspection in May 2015. We therefore visited the Raynor Road branch surgery as part of this inspection. Although staff we spoke with said that they communicated as a close team on a day to day basis, we found that some staff were unclear regarding the status of the plans to relocate the branch surgery at Raynor Road. Staff we spoke with explained how they had prepared to move and were ready to transfer services to suitable premises on multiple occasions, however plans had failed and staff were unsure as to what the future plans of the branch surgery were. These discussions also highlighted how staff were aware that Raynor Road was not a suitable premises to deliver care and treatment and that the practice team had attempted to resolve the issue by looking to move to a suitable premises.

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 We found that staff had not assessed the risk in the absence of various emergency medicines. There were gaps in the records for monitoring the cold chain.