Fiveways Health Centre

Inspection report

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services well-led?	

Overall summary

At the previous inspection in January 2018 the practice was rated as inadequate overall and placed into special measures.

We carried out a comprehensive inspection of Five Ways Health Centre on 9 January 2018. Significant failings were identified in the management of hospital correspondence and there was no system in place to ensure the appropriate management and actioning of safety alerts. During the inspection we reviewed the QOF clinical registers, where we identified several patients who had been inappropriately excluded from the registers and therefore had not received the appropriate care and treatment. We found that the practice administrator was making decisions concerning the exception reporting of patients on the clinical registers without any supervision or clinical support. We found the management of significant events and the sharing of learning needed to be strengthened and governance arrangements were not embedded. There were no systems or processes to assess and monitor patients' outcomes and the practice were unable to demonstrate quality improvements, this also included having no effective system in place to obtain patients' views.

Under Section 29 of the Health and Social Care Act 2008 two warning notices were issued in respect of the following regulated activities: Treatment of Disease, Disorder or Injury and Diagnostic and Screening Procedures. The provider was required to submit an action plan of planned improvements to mitigate the risks identified. A Section 64 letter was also issued, where the provider was required to provide the Care Quality Commission with specified information and documentation under Section 64 of the Health and Social Care Act 2008.

We carried out this focused unannounced inspection on 6 June 2018 to review the actions the practice had taken following the warning notices and the Section 64 letter and to confirm the provider had implemented their action plan. As a result, there was no rating awarded following this inspection.

Our key findings at this inspection were as follows:

- At the inspection in January 2018 we identified significant failings in the management of hospital correspondence. At this inspection we found that there was still no effective process in place and from the letters and patients records we viewed we found significant concerns demonstrating that patients had not received the appropriate care and treatment.
- From the sample of correspondence and patients records we viewed on the day of inspection, we found significant concerns in the lack of systems in place to review children and young people who had attended Accident and Emergency (A&E) and who were on the child protection register.
- Clinical staff did not always assess patients' needs and deliver effective care in line with current evidence based guidance.
- Some of the patient records we reviewed showed care and treatment was not delivered in line with recognised professional standards and guidelines, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The practice told us they had introduced a system to ensure safety alerts were actioned appropriately by clinical staff, however we identified failings in the current system as two alerts concerning potential risks to patients had not been received and there was evidence that alerts had been shared with the wider clinical team.
- The practice was unable to demonstrate that all staff working within the practice had the necessary skills, knowledge and where appropriate training to work within the competencies of their specific role.
- The practice had implemented a system for significant events and updated their policy, however we found the new system had not been embedded and learning from significant events and incidents had not been documented, discussed or shared with the whole team.
- The practice had set up an action plan to gather patient feedback, this included conducting an internal survey to gather patients' views, however this had not been implemented and the practice was unable to demonstrate any improvements in obtaining patient feedback through internal surveys or the existence of a patient participation group.
- The lead GP had commenced quality improvement through clinical audit, however we saw little evidence that audits were driving improvement in performance or patient outcomes.

Overall summary

- A review of patients on high risk medicines had been completed and the lead GP had implemented a system to ensure patients on these medicines were reviewed regularly.

Due to the significant failings we identified in the management of patient care and treatment on the unannounced inspection on 6 June 2018 urgent action was taken to protect the safety and welfare of people using this service. Under Section 31 of the Health and Social Care Act 2008 a temporary suspension of four months was imposed on the registration of the provider and registered manager in respect of the following regulated activities: Diagnostic and screening procedures, Treatment of disease, disorder or injury, Family planning, Maternity and midwifery services and Surgical procedure from Five Ways Health Centre, Ladywood Middleway, Birmingham B16 8HA.

This notice of urgent suspension of the provider and registered manager's registration was imposed due to the seriousness of the findings relating to lack of appropriate care and treatment and because we believed that a person would or may be exposed to the risk of harm if we did not take this action. The suspension took effect from Friday 8 June 2018. We have shared our findings with the Clinical Commissioning Group (CCG) and the CQC and CCG are working together to address the concerns identified.

The service will be kept under review and if needed further urgent enforcement action could be taken. Another inspection will be conducted within the four months suspension period and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Professor Steve Field CBE FR FFPH FRCGP
Chief Inspector of General Practice

Population group ratings

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)	

Our inspection team

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

Background to Fiveways Health Centre

Five ways Health Centre is located in Ladywood Middleway, Birmingham. The surgery operates out of purpose-built premises. The practice provides primary medical services to approximately 4,500 patients in the local community. The lead GP (female) has the support of GP locums, a part time practice nurse (female) and health care assistant (male). The non-clinical team consists of administrative and reception staff and a practice manager.

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

The practice is open between 8am to 8pm Mondays to Fridays and 10am to 12 midday Saturday and Sunday. Appointments were from 9.30am to 12.30pm and 4pm to 6.30pm Monday to Friday. Extended hours appointments are available Monday to Friday between 6.30pm to 7pm and 10am to 11.30am Saturday and Sunday. Telephone consultations are available if patients requested them; home visits were also available for patients who are unable to attend the surgery if they were within the practice boundaries. When the practice is closed, primary medical services are provided by Primecare, an out of hours service provider and the NHS 111 service and information about this is available on the practice website.

The practice is part of NHS Sandwell & West Birmingham Clinical Commissioning Group (CCG). The CCG serves communities across the borough. (A CCG is an NHS Organisation that brings together local GPs and experienced health care professionals to take on commissioning responsibilities for local health services).

Are services safe?

At our previous inspection on 9 January 2018, we rated the practice as inadequate for providing safe services as the arrangements in respect of effective systems to reduce the risk of harm to patients were not in place or embedded to ensure the delivery of safe care and treatment. Concerns relating to the management of safety alerts, monitoring of patients on high risk medicines, lack of formal arrangements to ensure continuity of clinical cover over the long term had not been clearly established. We found significant failings in the management of hospital correspondence and that the practice did not have sufficient procedures in place for the management of infection control. The system for recording significant events was ineffective and the practice were unable to demonstrate what actions had been taken to minimise future risk. A Warning Notice was issued on 28 February under Section 29 of the Health and Social Care Act 2008 where the provider was required to become compliant with Regulation 12 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 27 March 2018.

We found minimal improvements had been made when we undertook a follow up inspection on 6 June 2018 and identified further risks that had not been acted on. We have not amended the rating as we only reviewed the Warning Notice findings and the actions the practice had taken to reduce the risk to patients.

Safety systems and processes

The practice did not have clear systems to keep people safe and safeguarded from abuse.

- The practice had some systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role.
- On the day of inspection, we were told there were no active concerns regarding patients on the safeguarding register, however we identified several issues and found significant concerns relating to the lack of systems in place to review children and young people who had attended A&E and who required follow up, placing these patients at risk of harm.
- Staff took some steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect, but we found there was no joint working arrangements in place with the health visiting service.
- Since the previous inspection the practice had updated their infection control policy and all staff had received the appropriate training for their role.

Risks to patients

There were inadequate systems to assess, monitor and manage risks to patient safety.

- Some arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. Since the previous inspection, we were told that the lead GP had been given time to oversee the clinical administration at the practice.
- The practice were unable to demonstrate that all staff working within the practice had the necessary skills, knowledge and where appropriate training to work within the competencies of their specific role.
- When there were changes to services or staff the practice was unable to demonstrate they had assessed and monitored the impact on safety.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

Information to deliver safe care and treatment

- Staff did not have the appropriate information they needed to deliver safe care and treatment to patients. From the sample of clinical correspondence we viewed, we found letters had not been reviewed or acted on and medical conditions had not been coded appropriately.
- The system for ensuring full and accurate contemporaneous records was not adequate. Following a review of patients records we found ineffective recording of examination, investigation and follow up results .
- There was no effective process in place for clinicians to make timely referrals. We found evidence of two referrals that had been requested in 2017 by secondary care that not had been actioned.

Appropriate and safe use of medicines

Are services safe?

The practice did not have reliable systems for appropriate and safe handling of medicines.

- We identified issues regarding prescriptions awaiting collection. We reviewed a sample of patients' records and found significant concerns regarding the care and treatment of five patients. The practice had inadequate systems to ensure prescribing and prescriptions were managed appropriately for the delivery of safe care and treatment. This included the management of long term conditions, medication reviews and treatment that did not follow NICE guidance.
- We found evidence that staff had not prescribed medicines to patients as requested in clinical correspondence.
- Patients' health was not monitored in relation to the use of medicines or followed up appropriately. We found evidence that patients were not involved in regular reviews of their medicines.
- Since the previous inspection, the clinical staff had carried out a review of patients on high risk medicines and had reviewed each patient before medicines were prescribed.

Lessons learned and improvements made

- The practice was unable to demonstrate they had learned and made improvements when things went wrong.
- The practice had implemented a system for reviewing and investigating incidents and significant events. However, we found that learning and sharing had not become embedded. For example, a clinical incident that had occurred had not been discussed or learning shared to mitigate future risk.
- The practice continued to have a lack of systems in place for reviewing and investigating when things went wrong. The practice could not demonstrate they had learned from incidents, safeguarding concerns or acted to improve safety in the practice.
- The practice told us they had introduced a system to ensure safety alerts including those received from the Medicines and Healthcare Products Regulatory Agency (MHRA) were actioned appropriately by clinical staff. However, we found the system was not adequate to ensure all alerts had been received, acted on and discussed with the team to ensure staff were aware of potential risks and actions taken.

Please refer to the Evidence Tables for further information.

Are services effective?

At our previous inspection on 9 January 2018, we rated the practice as inadequate for providing effective services as the arrangements in respect of effective needs assessment, care and treatment were not being provided. We found that clinicians did not always assess patients' needs and delivered care and treatment in line with current legislation, standards and guidance and the practice did not have a programme of quality improvement activity or evidence of routine reviews being completed to monitor the effectiveness and appropriateness of the care provided.

We found no improvements had been made when we undertook a follow up inspection on 6 June 2018. We have not amended the rating as we only reviewed the Warning Notice findings and the actions the practice had taken to reduce the risk to patients.

Effective needs assessment, care and treatment

Clinical staff did not always assess needs and deliver care and treatment in line with current legislation, standards and guidance and were unable to demonstrate systems were in place to keep clinicians up to date with current evidence based practice.

- The practice could not demonstrate that these guidelines were monitored through risk assessments, audits and random sample checks of patient records.
- Patients' immediate and ongoing needs were not fully assessed. This included their clinical needs and their mental and physical wellbeing.
- On reviewing a sample of patients' clinical records we found a failure to adequately investigate, respond to abnormal results and prescribe appropriate treatment. This placed patients at risk of having undiagnosed and untreated conditions and inadequate support to aid patients' independence.

Older people:

- We found the management of patients' care was not effective and placed patients at risk.
- The practice were unable to demonstrate they followed up on older patients discharged from hospital. We found examples where prescriptions had not been updated to reflect any extra or changed needs.
- The practice was responsive to the needs of older people, and offered home visits to patients and urgent appointments for those with enhanced needs.

People with long-term conditions:

- On reviewing a sample of patients records we found patients with long term conditions had not received regular monitoring and follow up to ensure they were receiving appropriate care and treatment to minimise the risk of further complications whilst ensuring current treatment was still appropriate.
- The practice had implemented a system for the management of patients on high risk medicines. We found patients in receipt of prescriptions for medicines, which required closer monitoring, were being reviewing regularly to ensure their treatment was in line with prescribing recommendations.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Publicised data showed the uptake rates for the vaccines given ranged between 71% to 85% which were below the national target of 90%.
- The practice were unable to demonstrate they had arrangements for following up failed attendance of children's appointments following an appointment in secondary care.

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

- The practice's uptake for cervical screening was 51%, which was below the 80% coverage target for the national screening programme and the practice were unable to demonstrate they had taken action to encourage patients to attend screening.
- The practice were unable to demonstrate the appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances, However from a sample of patients records we viewed we found that patients' needs were not monitored appropriately.

Are services effective?

- The practice held meetings with other health care professionals in the case management of vulnerable patients, however from the sample of patients' records we viewed we found concerns that had been highlighted were not acted on.

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

- The practice were unable to demonstrate they had specifically considered the physical health needs of patients with poor mental health.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Monitoring care and treatment

The practice could demonstrate they had commenced an audit plan they had put in place; however we saw little evidence that audits were driving quality improvement activity this included a review of the effectiveness and appropriateness of the care provided

- At the previous inspection in January 2018 we found administration staff were making decisions concerning the exception reporting of patients on the clinical registers without any supervision or clinical support. The staff told us at this inspection that clinical staff were reviewing patients before being exception reported and administration staff were no longer carrying out this role.
- The practice was unable to demonstrate that they used information about care and treatment to make improvements. On reviewing a sample of patients' records we found patients with long term conditions had not received regular monitoring and follow up to ensure they were receiving the appropriate care and treatment.

Effective staffing

The practice were unable to demonstrate that all staff working within the practice had the necessary skills, knowledge and where appropriate training to work within the competencies of their specific role.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews, however from a sample of medical records we viewed, we found they did not contain an accurate, complete and contemporaneous record of the care and treatment provided.
- The practice was unable to demonstrate they understood the learning needs of staff . There was limited evidence of support for staff who were being developed for new roles. We found administration staff were coding medical conditions on behalf of the clinical staff, without any training or clinical oversight to ensure the appropriate code had been used. From a sample of patients' records we viewed we found examples of incorrect coding of conditions.
- At the previous inspection we found the health care assistant had received no specific training for the administering of vaccines, but relied on previous medical training as a general practitioner. During this inspection, the inspection team were provided with conflicting information about the tasks and duties undertaken by the health care assistant. We found no evidence that the health care assistant had received the appropriate training to work within the competencies of their specific role.
- We found the health care assistant continued to administer vaccinations under Patient Group Directions (PGDs), which is not permitted within the role of a health care assistant. (A PGD allows healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription).
- The practice had not implemented a system to monitor the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. From a sample of patients' records we viewed, we found a lack of detail, adequate history and examination had taken place to make an appropriate diagnosis and arrange appropriate investigation. Also, we found there was a lack of clinical reasoning to support decision making with regards to clinical management.
- There was no clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Are services effective?

Staff worked with some health and social care professionals to deliver care and treatment, but due to the lack of clinical leadership and managerial capacity there were no assurances these reviews were effective and met patients' needs.

- The practice shared some information with relevant professionals when discussing care delivery for people however due to the significant failings of reviewing clinical correspondence and inadequate documentation of consultations the practice was unable to demonstrate accurate patient records.
- They shared information with, and liaised, with community services, social services and carers for housebound patients, but we found no joint working arrangements were in place with health visitors and community services for children who had relocated into the local area.
- From a sample of patients records we viewed, we found patients had not received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.

Please refer to the Evidence Tables for further information.

Are services well-led?

At our previous inspection on 9 January 2018, we rated the practice as inadequate for providing well led services as the governance arrangements to reduce the risk of harm to patients were not in place or embedded and there was no clinical or managerial leadership in place to ensure the mitigation of risk. This included a lack of embedded systems and processes in place to assess and monitor patients' outcomes, staff carrying out roles that they had not received the appropriate training for and were outside of their competencies. There were no systems to demonstrate quality improvement and the provider had not actively sought the views of patients to monitor satisfaction and drive improvements. A Warning Notice was issued on 28 February under Section 29 of the Health and Social Care Act 2008 where the provider was required to become compliant with Regulation 17 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 29 May 2018.

We found no improvements had been made when we undertook a follow up inspection on 1 June 2018 and identified further risks that had not been acted on. We have not amended the rating as we only reviewed the Warning Notice findings and the actions the practice had taken to reduce the risk to patients.

Leadership capacity and capability

Leaders were still unable to demonstrate they had the capacity and skills to deliver high-quality, sustainable care.

- We found there was no effective clinical or managerial leadership at the practice. The management team did not have the experience, capacity and skills to effectively lead the practice.
- Since the previous inspection the practice told us they had plans to employ more clinical staff, however we found they were still relying heavily on locums to ensure adequate clnical capacity.
- The management team were knowledgeable about issues relating to the quality and future of services, however they were unable to demonstrate effective leadership to challenge and address them.
- At the last inspection we found the practice manager had delegated many of the roles within the practice to the administrator. The administrator continued to carry out roles for which they did not have the relevant skills and experience. For example clinical coding of conditions and practice management duties.

Vision and strategy

The practice did not have a clear vision and credible strategy to deliver high quality, sustainable care and we found continued breaches in regulations relating to safe care and treatment and good governance.

- There was limited vision and we found the delivery of quality care and good outcomes for patients were not being realised.
- The practice lacked capacity and capability in clinical leadership to support or to implement a vision and strategy. Staff were unaware of the strategy and their role in achieving it.
- The practice did not plan its services to meet the needs of the practice population.
- The practice did not monitor progress and we found limited improvements.

Culture

The practice did not have a culture of high-quality sustainable care.

- We found the provider did not prioritise quality care and had significant failings in leadership to ensure patients were reviewed and monitored effectively.
- The practice did not focus on the needs of patients. Due to the demands on the principal GP, the doctor had limited time to evaluate their clinical work.
- Leaders and managers were unable to demonstrate how they acted on inconsistent performance.
- There were some processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received an appraisal in the last year, however we found staff carrying out advanced roles that they had not received the appropriate training for and were working outside of their competencies. Staff were supported to meet the requirements of professional revalidation where necessary.

Governance arrangements

Are services well-led?

The practice were unable to demonstrate improvements had been made since the warning notices had been issued and we found the practice had not ensured there were clear responsibilities, roles and systems of accountability to support good governance and management In place.

The provider had no effective systems were in place to drive improvements, including assurance of the quality and safety of the services is in place. The governance arrangements did not provide sufficient clinical and managerial oversight to ensure the delivery of good quality care. This included both clinical and non-clinical governance arrangements that identified, assessed and managed risks to patient safety.

The lead GP faced challenges in maintaining an overview of the practice due to lack of regular clinical support and practice demand. This was reflected in the high use of long term locums in providing clinical care and the quality and safety of services provided.

The practice had a number of policies and procedures in place to govern activity and these were available to all staff. However, there were gaps in governance arrangements in relation to assessing, monitoring and mitigating risks. For example:

- Patients were at risk of harm because effective systems were not in place to ensure risks were sufficiently mitigated and their management was embedded. For example, Staff were clear on their roles and accountabilities in respect of safeguarding, but we found safeguarding concerns had not been acted on, placing patients at risk of potential harm.
- Clinical staff did not always assess patients' needs and deliver effective care in line with current evidence based guidance. From a sample of medical records we viewed, we found they contained inadequate documentation of the history, examination and management plan in respect of each patient's consultation.
- Current processes for the management of medicine alerts issued by The Medicines and Healthcare products Regulatory Agency (MHRA) did not offer assurance that these were reviewed and acted on appropriately.
- There was limited evidence of effective auditing systems in place to drive improvements including clinical audits.
- Staff added clinical codes to patients' medical records, however there was no system in place to monitor accuracy of information and to ensure the appropriate codes had been used by a suitably qualified clinician.
- Practice leaders had implemented policies and procedures to ensure safety and mitigate risk, but we found these had not been embedded effectively and the management team had not assured themselves that they were operating as required.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance, this included mitigating risks relating to the health and safety and welfare of people using the service.

- There was no effective process to identify, understand, monitor and address current and future risks including risks to patient safety. This included care and risk assessments, care plans, investigation and test results
- The practice had no processes in place to manage current and future performance. Practice leaders had no oversight of safety alerts and incidents to ensure they had been acted on appropriately and shared with the wider team.
- The lack of effective systems in place were putting patients at risk and that the GP lead did not have the capability to lead effectively and drive improvement.
- The practice was able to demonstrate one clinical audit had made a positive impact on quality of care and outcomes for patients. However, there was no clear evidence of action to change practice to improve quality.
- The practice had not considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice did not have appropriate and accurate information.

- Quality and Outcomes framework (QOF) data was used to support the follow up of patients with long term conditions, but as the system for ensuring full and accurate records was not effective, clinicians did not have access to up to date medical history and accurate medicine records. From a sample of patient records' we found inadequate documentation of the patient's medical history, clinical signs and where necessary, appropriate examination. This increased the risk of patients receiving inappropriate treatment as there was inadequate documentation of consultations within the medical records.

Are services well-led?

- The information used to monitor performance and the delivery of quality care was inaccurate. From the sample of patients records we viewed we found inconsistences in the care and treatment provided and the practice were unable to evidence they had plans to address any identified weaknesses.
- The practice used information technology systems, however we found examples of incorrect clinical coding as administration staff were coding clinical conditions on patients' records with no clinical oversight.

Engagement with patients, the public, staff and external partners

The practice did not involve patients, the public, staff and external partners to support high-quality sustainable services.

- The practice had not implemented their action plan to gather patient feedback through internal surveys. Since the inspection in January 2018 the national patient survey results published in July 2017 had been reviewed and discussed with the team, but the practice were unable to demonstrate any improvements in obtaining patient feedback through surveys or a patient participation group.

Continuous improvement and innovation

There was no evidence of innovation or service development and improvement was not being explored or discussed among staff and the management team.

- There was limited focus on continuous learning and improvement.
- The practice made use of some internal and external reviews of incidents and complaints, but we found this was ineffective in sharing and learning with the wider team to make improvements.

Please refer to the evidence tables for further information.