

Jubilee Health Centre

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

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Jubilee Health Centre on 9 January 2017. Overall, the practice is rated as inadequate.

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

- Patients were at risk of harm because some systems and processes were not well embedded or operated effectively. For example, the practice had not gained assurance that appropriate recruitment checks for locum staff had been undertaken prior to their employment. Vaccination expiry dates were not being monitored; and systems for managing patient safety alerts and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were not effectively managed.
- In the absence of specific emergency medicines, the practice did not carry out a documented risk assessment to assess how staff would respond to

certain medical emergencies. Following the inspection the practice provided evidence of guidelines which staff were required to follow when responding to medical emergencies.

- The process for managing high risk medicines, which require closer monitoring, did not ensure patients were seen within recommended timeframes. There was no clear audit trail to demonstrate that requests for repeat medicines were approved by a clinician.
- Following the inspection, we requested specific information relating to medicine management. The practice response showed further gaps in the management of medicines, which require closer monitoring.
- Staff were clear about reporting incidents, near misses and concerns and there was evidence of learning and actions taken as a result of incidents.
- Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. However, there were areas

Summary of findings

where documentation did not demonstrate where staff had assessed patients' needs and delivered care in line with current evidence based guidance. For example, there were incomplete care templates for some medical conditions.

- Data from the Quality and Outcomes Framework (QOF) showed variations in patient outcomes compared to the local and national average with a high exception reporting rate in some clinical areas. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice was unable to demonstrate how they had used clinical audits to improve outcomes for patients and the quality of the service provided.
- Care Quality Commission comment cards we received as part of the inspection showed that patients felt that they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Comments also highlighted the ease of making appointments with a named GP and there was continuity of care.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Although there was a leadership structure and staff felt supported by management there were areas where governance arrangements were not established, effectively operated or implemented. For example; the practice did not operate effective systems to enable staff to manage risks, ensure relevant nationally recognised guidance were being followed or establish a coherent approach to addressing the quality and performance of specific clinical areas. Although the practice had a system for monthly infection control audits, we saw that the practice were not effectively following their process. For example, the last audit had been carried out in May 2016.

The areas where the provider must make improvement are:

- Implement an effective system to ensure compliance with patient safety alerts and medicines alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Establish and operate effective procedures to ensure that appropriate recruitment checks have been carried out prior to commencement of employment.
- Ensure that in the absence of some emergency medicines risks are identified, assessed and formal plans established to mitigate risks associated with anticipated emergencies.
- Establish effective systems and processes to identify; monitor and respond to areas of performance where the practice is performing below local and national averages.
- The practice must establish effective systems to ensure the appropriate monitoring of patients in receipt of high-risk medicines is being carried out as part of, and align with, patients care and treatment plans and ensure clear demonstration of clinical oversight when adding medicines to patient records.
- Ensure the proper and safe management of vaccinations to ensure stock levels remain within manufacturers' expiry date.
- Ensure relevant nationally recognised guidance is implemented to reflect best practice and improve patients care and treatment.
- Establish and implement effective systems and processes. For example, establish an effective process for handling repeat medicine requests, implement systems for monitoring PGDs to ensure they remain valid, establish an effective system to monitor and improve the quality and safety of services provided.

The areas where the provider should make improvement are:

- Ensure that audits such as infection control are carried out in line with the practice policy and procedures.
- Gain assurance that appropriate fire protection arrangements are in place.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin

Summary of findings

the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a

further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

- We saw areas where risks were not managed well enough to ensure patients were kept safe. For example, the practice were unable to demonstrate that they had gained assurance that locum recruitment checks had been carried out. Following the inspection the practice provided evidence which showed that appropriate recruitment checks had been carried out.
- There were areas of medicine management which the practice were unable to demonstrate they had followed nationally recognised guidance or carried out reviews in line with patients care and treatment assessments.
- The practice were unable to demonstrate compliance with relevant patient safety alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). Actions aimed at responding to anticipating emergencies such as fire risks and medical emergencies' were not operated effectively. For example, in the absence of medicines used to respond to anaphylaxis (an allergic reaction) and epileptic fits the practice did not carry out a risk assessment. Following the inspection the practice provided assurance that staff had access to medicines and guidance were in place to enable staff to respond to medical emergencies effectively.
- Although the practice had a system for monthly infection control audits, we saw that the practice were not effectively following their process. For example, the last audit had been carried out in May 2016.
- The practice did not establish or operate an effective system to ensure vaccinations were within their expiry dates. We saw that some Patient Group Directions (written instructions for nurses) were out of date.
- There was an effective system in place for reporting and recording significant events. For example, the practice used patient safety and risk management software to record safety incidents. Staff were able to demonstrate where lessons were shared and actions taken in response to safety incidents.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.

Inadequate



Summary of findings

Are services effective?

- There were areas of practice where clinicians were unable to demonstrate that they had assessed needs and delivered care in line with national guidelines. For example, there were incomplete care templates for some medical conditions.
- There was limited evidence that audits were driving improvement in patient outcomes.
- Data from the Quality and Outcomes Framework (QOF) showed areas of low QOF scores in patient outcomes compared to the local and national average with a high exception-reporting rate in some clinical areas. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- For example, overall exception reporting for dementia was 25%, compared to CCG and national average of 12%.
- Staff had the skills, knowledge and experience to deliver care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Multidisciplinary working with other health care professionals was taking place to understand and meet the range and complexity of patients' needs. However, the practice did not operate a system within the practice to track correspondence such as medicine updates and test results received from secondary care.

Inadequate



Are services caring?

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Completed Care Quality Commission comment cards we received showed that patient felt they were treated with compassion, dignity and respect; and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible within the practice and via the practice web site.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 2% of patients on the practice list as carers. There was a carer's' corner within the reception area, which provided carers with a wide range of comprehensive information about support services.

Good



Summary of findings

Are services responsive to people's needs?

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice had improved accessibility by working with a neighbouring practice to allow patients to access appointments on Thursdays and Saturdays between 3pm and 4pm when the practice was closed.
- Care Quality Commission comment cards we received showed that patients found it easy to make an appointment. Urgent appointments were available on the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Inadequate



- Although the practice had an overarching governance framework, we saw areas where systems and processes were not effectively operated. The practice did not establish effective arrangements to monitor and improve the quality of the service or identify and manage risks.
- For example, the practice did not establish an effective system to monitor, ensure or demonstrate that relevant nationally recognised guidance was being followed, and medicine reviews were not always carried out in accordance with treatment plans and nationally recognised guidance. We also saw that systems for monitoring and actions aimed at improving QOF performance had not been effectively operated or widely communicated within the practice.
- The management of patient safety alerts such as patient alerts and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were not operated effectively. As a result, we saw that some alerts relating to specific medicines had not been acted upon.
- The provider was aware of and complied with the requirements of the duty of candour. The management team encouraged a culture of openness and honesty.
- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with as part of the inspection were clear about the vision and their responsibilities in relation to it.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular practice meetings.
- The practice sought feedback from staff. Although the practice did not have an active patient participation group (PPG) we saw alternative measures in place in order to seek feedback from patients, which it acted on.

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

The provider was rated as inadequate for safety, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice offered personalised care to meet the needs of the older people in its population. All patients had a named GP.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Members of the clinical team visited local nursing and care homes to provide patient care, older patients were offered carers support if needed.
- The practice provided health promotion advice and literature which signposted patients to local community groups and charities such as Age UK.
- The practice was accessible to those with mobility difficulties.

Inadequate



People with long term conditions

The provider was rated as inadequate for safety, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Overall performance for diabetes related indicators was comparable to the local and national average. For example 76% had a blood glucose reading within a specific range in the preceding 12 months (01/04/2015 to 31/03/2016) compared to the CCG and national average of 77% and national average of 78%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and for those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Inadequate



Summary of findings

- Staff we spoke with explained that the practice offered a range of services in-house to support the diagnosis and monitoring of patients with long term conditions. These included spirometry, phlebotomy (taking blood for testing), and followed recognised asthma pathways.
- However, the percentage of patients with atrial fibrillation (an irregular and sometimes fast pulse) treated using recommended therapy was 68%, compared to CCG and national average of 87%. The practice did not establish an effective process for monitoring patients in receipt of medicine aimed at reducing risks.
- 74% of people diagnosed with asthma had a review recorded in the last 12 months; this was comparable to CCG average of 75% and national average of 76%. However exception reporting rate was 32%, compared to CCG average of 4% and national average of 8%.

Families, children and young people

The provider was rated as inadequate for safety, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were comparable to local and national averages for all standard childhood immunisations. Eight week baby checks were undertaken and patients who missed appointments were recalled and referred to the Health Visiting Team following three missed appointments.
- The practice was accessible for pushchairs, had baby changing facilities and supported breast feeding
- Staff we spoke with were able to demonstrate how they would ensure children and young people were treated in an age-appropriate way and that they would recognise them as individuals.
- The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 80% and the national average of 81%. There was a policy to offer telephone reminders and follow up invitation letters for patients who did not attend for their cervical screening test.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Inadequate



Summary of findings

Working age people (including those recently retired and students)

The provider was rated as inadequate for safety, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified, and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- The practice offered travel vaccinations available on the NHS and staff sign posted patients to other services for travel vaccinations only available privately such as yellow fever centres (able to provide vaccination for a tropical virus disease transmitted by mosquitoes which affects the liver and kidneys).
- The practice provided new patient health checks and routine NHS health checks for patients aged 40-74 years.
- Data from the national GP patient survey indicated that the practice were above local average regarding phone access and above local as well as national averages regarding opening times.

Inadequate



People whose circumstances may make them vulnerable

The provider was rated as inadequate for safety, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients; staff explained that vulnerable patients who lived alone were signposted to carers support services.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. 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.

Inadequate



Summary of findings

People experiencing poor mental health (including people with dementia)

The provider was rated as inadequate for safety, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- 95% of patients diagnosed with dementia had their care plan reviewed in a face-to-face review in the preceding 12 months (01/04/2015 to 31/03/2016), compared to CCG and national average of 84%. However, the practice exception reporting rate was 17% compared to CCG and national average of 7%.
- The practice was unable to demonstrate that they had carry out advance care planning for patients with dementia. Further data requested following the inspection showed that care plans had not been completed.
- Overall exception reporting for dementia was 25%, compared to CCG and national average of 12%.
- Performance for mental health related indicators was comparable to the national average. For example, 90% had a comprehensive, agreed care plan documented in their record in the preceding 12 months, compared to the CCG average of 91% and national average of 89%. However, exception reporting rate was 55%, compared to CCG average of 15% and national average of 13%.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. For example, the practice offered a counselling service for anxiety and depression, where a counsellor visited the surgery.
- Staff we spoke with explained that patients experiencing poor mental health were told about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had an understanding of how to support patients with mental health needs and dementia.

Inadequate



Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing at or above local and national averages in most areas. Three Hundred survey forms were distributed and 111 were returned. This represented a 37% completion rate.

- 63% of patients found it easy to get through to this practice by phone compared to the CCG average of 60% and national average of 73%.
- 94% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 75% and national average of 85%.
- 86% of patients described the overall experience of this GP practice as good compared to the CCG average of 75% and national average of 85%.
- 79% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 64% and national average of 78%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards, which were all positive about the standard of care received. Patients felt that staff were professional, welcoming and compassionate. Patients also felt that staff showed empathy when responding to their requests and provided appropriate information when required.

Areas for improvement

Action the service MUST take to improve

- Implement an effective system to ensure compliance with patient safety alerts and medicines alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Establish and operate effective procedures to ensure that appropriate recruitment checks have been carried out prior to commencement of employment.
- Ensure that in the absence of some emergency medicines risks are identified, assessed and formal plans established to mitigate risks associated with anticipated emergencies.
- Establish effective systems and processes to identify; monitor and respond to areas of performance where the practice is performing below local and national averages.
- The practice must establish effective systems to ensure the appropriate monitoring of patients in receipt of high-risk medicines is being carried out as part of, and align with, patients care and treatment plans and ensure clear demonstration of clinical oversight when adding medicines to patient records.

- Ensure the proper and safe management of vaccinations to ensure stock levels remain within manufacturers' expiry date.
- Ensure relevant nationally recognised guidance is implemented to reflect best practice and improve patients care and treatment.
- Establish and implement effective systems and processes. For example, establish an effective process for handling repeat medicine requests, implement systems for monitoring PGDs to ensure they remain valid, establish an effective system to monitor and improve the quality and safety of services provided.

Action the service SHOULD take to improve

- Ensure that audits such as infection control are carried out in line with the practice policy and procedures.
- Gain assurance that appropriate fire protection arrangements are in place.

Jubilee Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Jubilee Health Centre

Jubilee Health Centre is located in the heart of Wednesbury Town, West Midlands within easy reach of the bus station, providing NHS services to the local community.

Based on data available from Public Health England, the levels of deprivation in the area served by Jubilee Health Centre is below the national average, ranked at two out of 10, with 10 being the least deprived. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The practice serves a higher than average patient population aged between 45 to 59 and 70 to 85 and over, and has a below average practice population aged between 20 to 24 and 30 to 44.

The patient list is approximately 4,320. Services to patients are provided under a General Medical Services (GMS) contract with the Clinical Commissioning Group (CCG). GMS is a contract between general practices and the CCG to deliver primary care services to the local community.

The surgery 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. For example, childhood immunisations.

The surgery is situated on the ground floor of a multipurpose building shared with other health care providers. Onsite parking is available for patients who display a disabled blue badge and for cyclists. Patients without a disabled blue badge are able to access local pay and display parking facilities. The surgery has automatic entrance doors and is accessible to patients using a wheelchair.

The practice staffing comprises of two male GP partners, one male locum GP and one Health Care Assistant. At the time of the inspection, the practice had recruited a practice nurse who was due to commence employment in January 2017. There is a practice manager, a medical administrator, six receptionists and one senior receptionist.

The practice is open between 8am and 7.15pm on Mondays, 8am to 6.30pm on Tuesdays, and Fridays, 8am to 8pm Wednesdays and 8am to 3pm on Thursdays.

GP consulting hours are from 8am to 7.15pm on Mondays, 8am to 6.30pm on Tuesdays, and Fridays, 8am to 8pm Wednesdays; 8am to 2pm on Thursdays. There are arrangements in place with a neighbouring practice where patients are able to access appointments on Thursdays from 3pm to 4pm and Saturdays from 3pm to 4pm. The practice has opted out of providing cover to patients in their out of hours period. During this time, services are provided by NHS 111 Primecare.

Detailed findings

Why we carried out this inspection

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 January 2017.

During our visit we:

- Spoke with a range of staff such as GPs, health care assistant, receptionists, administrators and managers.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Following the inspection, we requested specific information in order to gather further evidence.

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

We also looked at how well services were provided for specific groups of people and what good care looked 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).

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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff we spoke with told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The practice used an electronic patient safety system to record safety incidents. Staff we spoke with explained that this enabled the practice to gain a comprehensive oversight of incidents and activities required to reduce identified risks. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- There was a clinical lead responsible for reviewing and monitoring significant events to ensure they were acted on as appropriate. Lessons from incidents and significant events were routinely shared through clinical meetings and staff we spoke with was able to provide examples of incidents that had been discussed and acted on.
- The practice carried out thorough analysis of significant events. The practice took appropriate action and made changes to internal systems and processes because of significant events. For example, processes were implemented to ensure that all patient letters from secondary care services such as hospitals were checked by practice staff to ensure the details were correct.

There was a designated lead responsible for reviewing and disseminating safety alerts such as medical device alerts and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The designated lead we spoke with explained the process for managing alerts however; we saw that the practice did not establish an effective process for tracking or monitoring the completion of actions required. For example, we were told that alerts were emailed to clinicians and verbally discussed with

partners individually; however, the practice were not recording these conversations. We requested evidence of actions carried out for an alert relating to a specific medicine. Staff we spoke with were unable to provide evidence that the practice had received the alert or documentation to demonstrate that required searches to identify patients in receipt of a specific medicine had been carried out.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to safeguarded patients from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare.
- There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Conversations with staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to safeguarding children level three. Health care assistants had received level one safeguarding training for children and vulnerable adults.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Members of the management team explained that the lead GP had taken over the role of infection control clinical lead. There was an infection control protocol in place and staff had received up to date training.
- Staff we spoke with told us the practice carried out monthly infection control audits undertaken internally using a rapid improvement tool to identify risks and

Are services safe?

areas for improvement. We saw documentation, which evidenced that monthly audits were carried out up to May 2016. We discussed this with the infection control lead who was unable to provide an explanation as to why the practice had not continued with monthly audits or establish an alternative option. We saw evidence that action was taken to address any improvements identified as a result of the last recorded audit.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not provide assurance that these arrangements kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). For example, on receipt of clinical correspondence non-clinical staff were adding and removing medicines; staff we spoke with explained that all changes were carried out following the directions and supervision from clinicians. We saw examples of where medicines had been added following a request by external health professionals. However, there was no clear audit trail to demonstrate that a clinician at the practice approved requests for repeat medicines.
- The practice did not establish or operate an effective system to ensure the review of high risk medicines were completed before issuing a repeat prescription. For example, we saw that the monitoring of patients in receipt of medicines that require closer monitoring was not always being appropriately monitored. Following the inspection, we asked the practice to provide us with a report of patients requiring monitoring. The report further identified that medicine reviews were not always being carried out.
- Prescription stationery including blank prescription forms and pads were securely stored and there were well established and effective systems in place to monitor their use. However, the storing and monitoring of vaccinations were not managed effectively. For example, we saw that the practice had out of date nasal flu vaccine and shingles vaccinations dated December 2016. We also saw medicines stored in the practice medicine cupboard included patient details.
- The practice received support from the local CCG pharmacy team one day per week who carried out regular medicines audits to monitor efficiency and ensure prescribing was in line with best practice guidelines for safe prescribing. The practice provided meeting minutes, which showed discussions around the management of medicines such as pain relief. However,

there was no evidence to demonstrate that the practice had utilised best practice guidelines for safe monitoring of patients in receipt of high risk medicines, which required closer monitoring.

- Although Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation, we saw that some were out of date. (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). For example, we saw that the shingles vaccination, and nasal flu vaccine were dated August 2016.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken for permanent members of staff prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, we saw that the recruitment of locum GPs did not always follow the same recruitment checking process. For example, documents we viewed did not demonstrate that the practice had gained assurance that appropriate checks; for example, references; DBS checks and proof of identification had been carried out prior to clinicians start date. Members of the management team explained that this information had been requested however had not been received. Following the inspection the practice provided evidence which showed that appropriate recruitment checks had been carried out by an external locum recruitment agency.

Monitoring risks to patients

Risks to patients were assessed and well managed in most areas.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office, which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire equipment checks however, we saw that the last recorded fire drill was June 2016. When asked staff explained that fire drills were carried out by an external contractor however, the practice was unable to provide evidence to support this. Staff we spoke with were able to explain

Are services safe?

what to do in the event of a fire. Following the inspection the practice provided documentation which showed that a fire drill had been carried out by an external contractor in December 2016.

- Electrical equipment was checked by a professional contractor to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw that labels were attached to electrical equipment, which evidenced that they had been checked within the last 12 months.
- We saw that vaccination fridges were secure and vaccinations were appropriately stored within the recommended temperature range. Records were kept to record and monitor temperatures in line with national guidance.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff holidays were coordinated to ensure sufficient cover were in place. Members of the management team demonstrated how they effectively responded to the gap in practice nurse provision by securing support from neighbouring practices and recruiting a temporary practice nurse. We were told that the nurse was scheduled to start January 2017.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. However, not all potential risks had not been identified or explored; For example:

- Medicines we checked were in date and stored securely. We saw that emergency medicines were accessible to staff in a secure area of the practice and staff we spoke with knew of their location. However, medicines used to respond to anaphylaxis (an allergic reaction) and epileptic fits were located in the GPs home visit bag and the practice was left without access to these medicines while GPs carried out home visits. Staff we spoke with explained that they were able to access the local pharmacy and emergency services were able to respond in a timely manner when required. However, the practice was unable to provide a completed risk assessment to demonstrate that any potential risks had been explored with safety measures such as arrangements with the local pharmacy implemented. Following the inspection the practice advised the Care Quality Commission (CQC) that when GPs were undertaking home visits staff had access to emergency medicines which were located in two clinical rooms. The practice provided evidence of guidelines which staff were required to follow when responding to medical emergencies and a poster advising staff of emergency medicines location was visible in the administration office.
- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.
- All staff received annual basic life support training. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available. However, we saw that the content of the first aid kit; such as plasters and dressings were dated 2011.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. We were told that copies were located on site as well as off site.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There was some evidence that staff assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date with evidence based and nationally recognised guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. However, during the inspection we found that some medicines were not being prescribed in line with recommended guidelines. For example, we saw that 40 out of 180 patients in receipt of a specific medicine were being prescribed outside the recommended strength.
- When asked members of the clinical team were unable to demonstrate or access medical management plans such as templates used in the management of patients diagnosed with diabetes and dementia. The practice carried out a search to identify number of patients diagnosed with dementia; this showed that all patients identified did not have a care plan in place.
- Staff we spoke with explained that they attended study days such as applying dressings and taking electrocardiogram readings, (ECG is a test that can be used to check heart rhythms and electrical activity).
- Clinical staff had on-line access to the Green Book (a resource which has the latest information on vaccines and vaccination procedures) and monthly publications produced by Public Health England regarding changes to the immunisation programmes. Staff we spoke with also explained that they received updates from diabetes and asthma UK; staff had online access to the British National Formulary online (a publication, which reflects current best practice as well as legal and professional guidelines relating to the uses of medicines).

Management, monitoring and improving outcomes for people

Although the practice overall performance was comparable to local and national averages the practice were not effectively using the information collected for the Quality

and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice) to target specific areas. The most recent published results showed the practice had achieved 93% of the total number of points available; this was comparable to the local and national average of 95%. This practice was not an outlier for any QOF (or other national) clinical targets. However, there were areas where exception reporting rates were above local and national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2015/16 showed:

- Overall performance for diabetes related indicators was comparable to the local and national average. For example 76% had a blood glucose reading within a specific range in the preceding 12 months (01/04/2015 to 31/03/2016) compared to the CCG and national average of 77% and national average of 78%.
- The percentage of diabetic patients who had a blood pressure reading within a specific range was 73%, compared to CCG and national average of 78%. With an exception reporting rate of 15%, compared to CCG average of 8% and national average of 9%.
- Percentage of diabetic patients with a cholesterol measurement within a specific range was 81%, compared to CCG average of 79% and national average of 80%. With an exception reporting rate of 16%, compared to CCG average of 10% and national average of 13%.
- Performance for mental health related indicators was comparable to the national average. For example, 90% had a comprehensive, agreed care plan documented in their record in the preceding 12 months, compared to the CCG average of 91% and national average of 89%. With an exception reporting rate of 55%, compared to CCG average of 15% and national average of 13%.
- The percentage of patients with atrial fibrillation (an irregular and sometimes fast pulse) treated using recommended therapy was 68%, compared to CCG and national average of 87%; with a zero percent exception reporting rate.
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness

Are services effective?

(for example, treatment is effective)

using recognised methods was 92%, compared to CCG average of 88% and national average of 90%. With an exception reporting rate of 31%, compared to CCG average of 13% and national average of 12%.

- 95% of patients diagnosed with dementia had their care plan reviewed in a face-to-face review in the preceding 12 months (01/04/2015 to 31/03/2016), compared to CCG and national average of 84%. With an exception reporting rate of 17% compared to CCG and national average of 7%.
- However, during the inspection we saw that care plans had not been completed. Further data provided by the practice upon request following the inspection showed differences in QOF data and the information provided by the practice. For example, data provided by the practice showed that patients did not have a dementia care plan in place.
- Overall exception reporting for dementia was 25%, compared to CCG and national average of 12%.

We spoke with both clinical and non-clinical staff and found that staff were unable to provide a clear coherent account of how exception reporting was being managed. When asked staff we spoke with told us that GPs monitored QOF domains and non-clinical staff sent letters inviting patients in for reviews and operated a call and recall system. However, the QOF lead did not establish a targeted plan to address areas where exception reporting were above local and national averages. Non-clinical staff advised that they were aware of the practice performance, which they had raised with clinicians. Other members of the clinical team told us that as part of the Primary Care Commissioning Framework (PCCF is a framework used to commission services from GP practices to improve health and well-being) the practice secured support to recruit a GP to help the practice to improve their QOF performance. However, we found that a detailed account of this plan was not common knowledge throughout the clinical team.

There was limited evidence of quality improvement including clinical audit.

- The practice were unable to provide evidence of completed audits where the improvements made were implemented and monitored. For example, staff explained that they had carried out an antibiotic audit to prevent unnecessary prescribing; however, we saw that this was a survey rather than an audit. The survey highlighted 90% of patients were on a repeat antibiotic

prescription; and, notices were placed within the practice stating that this medicine was not a repeat item. However, the survey did not detail actions required to address the identified issues.

- Staff explained that a CCG pharmacist attended the practice once a week.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included, safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- Clinicians had access to medical records, investigations, care and risk assessments; however, when asked clinicians were unable to demonstrate an effective system used within the practice to access test results from secondary care and there were some incomplete care plans. For example, the practice were unable to demonstrate where they had completed care plans or carried out medicine reviews for patients diagnosed with dementia.
- The practice shared relevant information with other services in a timely way, for example when referring

Are services effective?

(for example, treatment is effective)

patients to other services. However, the practice did not operate a system within the practice to track correspondence such as medicine updates and test results received from secondary care. As a result this impacted the ability to effectively plan patient care.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Staff we spoke with told us that meetings took place with other health care professionals on a regular basis and care plans were routinely reviewed and updated for patients with end of life care needs. We saw minutes of Gold Standards Framework multi-disciplinary team meetings for patients with end of life care needs. (GSF is a framework used by frontline staff to improve the quality, coordination and organisation of care for people nearing the end of their life).

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, carers, those with long-term conditions and those at risk of developing a long-term condition such as diabetes.

- The practice provided patients access to services such as family planning, healthy lifestyle and coronary heart disease clinics. They made use of health trainers, smoking cessation and weight management services.

- There were dedicated leads for diabetes, sexual health, Chronic Obstructive Pulmonary Disease (COPD), Bowel Cancer and patients with learning disability. Staff explained that longer appointments were offered to patients on the learning disability register.
- There was a range of health promotion information displayed in the practice to support patients. Information and links to local services was also available on the practice website.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 80% and the national average of 81%. There was a policy to offer telephone reminders and follow up invitation letters for patients who did not attend for their cervical screening test. Staff we spoke with explained the failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice referred patients to secondary care services or accessed a neighbouring practice to ensure patients had access to a female sample taker.

The practice demonstrated how they encouraged patients to attend national screening programmes for bowel and breast cancer screening by using information in different languages and for those with a learning disability.

Data showed that the practice were performing comparable to local averages; however were below national average for the uptake of bowel cancer screening. For example:

- Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) was 72% compared to CCG average of 67% and national average of 72%.
- Females, 50-70, screened for breast cancer in last 6 months of invitation was 73% compared to CCG average of 65% and national average of 73%.
- Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) was 47%, compared to CCG average of 46% and national average of 58%.
- Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %) was 46%, compared to CCG average of 46% and national average of 58%.

Staff explained that they received notifications regarding patients who had not returned their testing kit. Staff provided evidence of letters, which had been sent to

Are services effective? (for example, treatment is effective)

identify patients. The letter included information leaflets and the offer to meet with a clinician for further discussion if appropriate. We were also told that when patients attended the surgery for general health related reasons the practice opportunistically discussed the benefits of screening programmes.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds were 90% which was comparable to the local and national expected coverage of 90%. Immunisation rates for Measles Mumps

and Rubella (MMR) vaccinations given to five year olds was 94% for first dose and 93% for the second dose, compared to CCG averages of 94% for first dose and 86% for second dose; and national averages of 94% for first dose and 88% for second dose.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff we spoke with knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 13 completed Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was at or above average for its satisfaction scores on consultations with GPs, nurses and patients interactions with reception staff. For example:

- 86% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 91%.

- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received were positive about their involvement in decisions about their care and treatment. Comment cards also demonstrated that patients felt listened to and supported by staff.

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

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and national average of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. A translate page and fact sheets for Non-English speaking patients were accessible via the practice web site.
- Information leaflets were available in easy read format, and we saw notices in reception advising patients that leaflets were available in different languages.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations, for example counselling and wellbeing services and support

Are services caring?

from community services. The practice had a carer's corner where they displayed a wide variety of services available for carers. Information about support groups were also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 81 patients as carers (2% of the practice list). Staff we spoke with told us that carers had access to annual health checks, flu vaccinations and a stress levels review. Data provided by the practice showed that 57% had received a flu vaccination in the past two years.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs to provide advice on how to access support services. Posters and information leaflets regarding various support services were located in the practice reception area as well as the practice web site.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice is part of Sandwell and West Birmingham CCG Federation (a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local community). Staff we spoke with explained that the practice also worked in partnership with Primary Care Commissioning Framework (PCCF) where they worked jointly to improve access. For example, patients were able to access appointments at a neighbouring practice as part of PCCF on Thursdays from 3pm to 4pm and Saturdays from 3pm to 4pm; access to a female GP were available during these times. The lead GP attended PCCF clinical meetings where future developments were discussed such as exploring the option of Sunday opening.

- The practice offered extended opening for appointments on Mondays from 8am to 7.15pm and Wednesdays from 8am to 8pm for patients who could not attend during normal weekday opening hours.
- The practice made use of information technology to improve patient access. For example, there was online access to clinical records for patients who signed up to the service, online appointment bookings; prescription requests and electronic prescription services (enables prescribers to send prescriptions electronically to a pharmacy of the patient's choice). The practice also offered patients the option of opting into summary care records (a system which provides healthcare professionals treating patients in different care settings with faster access to key clinical information).
- The practice offered patients the option of booking telephone consultations throughout the day.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Clinicians visited patients in local nursing homes.

- Same day appointments were available for children and those patients with medical needs that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS. Staff sign posted patients to other services for travel vaccinations only available privately such as yellow fever centre (able to provide vaccination for a tropical virus disease transmitted by mosquitoes, which affects the liver and kidneys).
- The practice had a hearing loop and made use of translation services when needed. Staff told us that if patients had any special needs this would be highlighted on the patient system.
- There were disabled facilities and the premises were accessible for pushchairs, baby changing facilities were available and a notice displayed offered patient privacy for breast feeding.
- Patients with no fixed abode were able to register at the practice and there were policies and procedures in place to support this.
- A range of diagnostic and monitoring services including spirometry, phlebotomy, ambulatory and home blood pressure monitoring were available at the practice for the convenience of patients.
- The practice participated in the national screening program for Chlamydia testing. Clinics were offered one evening per week aimed at young people aged between 17 to 24.

Access to the service

The practice is opened between 8am to 7.15pm on Mondays, 8am to 6.30pm on Tuesdays, Thursdays and Fridays, 8am to 8pm Wednesdays. The practice has opted out of providing cover to patients during the out of hour's period. During this time, services are provided by NHS 111 and Primecare. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was at or above local and national averages.

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 76%.

Are services responsive to people's needs? (for example, to feedback?)

- 63% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and national average of 73%.

The practice had a system in place to assess, whether a home visit was clinically necessary and the urgency of the need for medical attention.

Staff we spoke with advised us that patients who requested a home visit would be triaged by a GP. Staff explained that GPs would call the patient or carer in advance to gather information to allow an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, staff explained that alternative emergency care arrangements were made by the GP. Clinical and non-clinical staff we spoke with were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, posters were displayed, leaflet were available for patients to take away and the practice had a suggestion box which staff checked on a regular basis. Patients were also able to provide feedback via the practice web site.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and there was openness and transparency in dealing with the complaints. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action taken to improve the quality of care. For example, we saw discussions held with clinical and non-clinical staff regarding improving communication skills. Documentations showed that the practice liaised with NHS England and appropriate actions were taken to address identified concerns.

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

Although the practice had a vision to deliver high quality care and promote good outcomes for patients; the lack of effective clinical leadership impacted the GP partners' ability to work effectively together to achieve business continuity. As a result, the practice were unable to demonstrate high quality care for patients. .

- The practice had a mission statement which was displayed in the waiting areas and staff we spoke with on the day knew and understood the values.
- Although the practice had a strategy and supporting business plans, which reflected the practice vision and values, the GP partners did not establish an effective communication pathway to address areas which were not being operated effectively. For example, during the inspection the GP partners' engagement with the inspection was minimal. Therefore, this affected the practice ability to demonstrate how they worked in line with their mission statement; visions and values to deliver safe and effective care.

Governance arrangements

We found the practice's governance arrangements were not effective which meant systems and processes to assess; manage risks and enable the delivery of good quality care were not effectively established or embedded. For example:

- The process to monitor whether relevant nationally recognised guidance were being followed had not been established. We saw that high-risk medicines, which required closer monitoring, were not being monitored appropriately. There were areas where care plans had not been completed. The practice did not operate an effective system for actioning repeat prescription requests. This meant that non-clinical staff were adding and removing medicine without evidence of clinical input and audit trails to evidence these requests were not being maintained.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effectively managed. For example, the practice did not establish an effective process to monitor the completion of actions required following the receipt of

safety alerts such as medical device alerts and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). We saw that effective communication pathways to ensure clinicians were receiving and cohesively responding to alerts had not been established. The practice did not ensure Patient Group Directions remained valid, areas of the practice recruitment process were not operated effectively and the practice did not carry out risk assessments or document a plan to respond to medical emergencies in the absence of specific medicines. Following the inspection the practice provided evidence of guidelines which staff were required to follow when responding to medical emergencies.

- An understanding of the performance of the practice was maintained in some areas. However, there were areas where the practice did not establish an effective programme of regular clinical audits to assess, monitor or improve the quality and safety of the services provided. For example; clinicians were unable to provide documentations to support the completion of clinical audits and a coherent approach to address clinical QOF areas where the practice were performing below local and national averages. An in-depth understanding of reasons for high exception reporting had not been established.
- There was a clear staffing structure and staff we spoke with was aware of their own roles and responsibilities. The practice took prompt actions to fill a vacancy in the practice nursing team. However, we saw that some nurse related tasks had not been completed. For example; there were gaps in the completion of infection control audits, storage and monitoring of vaccinations and medicines were not effectively managed.
- Practice specific policies were implemented and were available to all staff.

Leadership and culture

Staff spoken with during the inspection were committed to providing a high quality service and we saw examples of good care. However, we found that the leadership structure was fragmented with a lack of ownership or coherent approach where gaps and service improvements were identified; therefore, this outweighed examples of good

Are services well-led?

Inadequate 

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

practice. This resulted in poor systems and processes to assess and manage risks and monitor the quality of the service, which affected the ability to effectively manage the service safely.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings and we saw documentations to support this.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported by the management team. All staff was involved in discussions about how to run and develop the practice, and the managers encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

Although the practice encouraged and valued feedback from patients, the public and staff, we were told that the practice did not have an active patient participation group (PPG). We saw posters in the reception area encouraging patients to join the PPG and information regarding the group were available on the practice website. Following the inspection members of the management team explained that they would be looking into the possibilities of starting a virtual PPG.

The practice sought patients' feedback and engaged patients in the delivery of the service through internal surveys and operated a suggestion box. For example, the practice received feedback from patients regarding their concerns about the number high volume of patients who did not attend their appointments (DNA) and the impact this were having on appointment availability. As a result, the practice carried out internal surveys to enable the practice to utilise appointments more effectively and reduce the volume of DNA. Surveys provided by the practice showed that between May and August 2016 there were 565 DNA. We saw that the practice either sent letters or telephoned all identified patients to discuss reasons for DNA their appointment. Patients were reminded to cancel appointments in advance if they no longer needed them, and staff were proactively contacting patients prior to their appointments. Data provided by the practice showed that overall DNAs reduced to 376 between September and December 2016.

The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance</p> <p>How the regulation was not being met:</p> <p>The registered person did not establish or operate effective systems or processes. For example, the practice did not establish systems for ensuring vaccinations were monitored to ensure stock levels remained within manufacturers' expiry date.</p> <p>The practice did not carry out a risk assessment to identify risks or establish formal processes to respond to medical emergencies in the absence of emergency medicines. For example, the practice did not document formal measures to respond to anaphylaxis (an allergic reaction) and epileptic fits when the practice were left without access to these medicines while GPs carried out home visits.</p> <p>The registered person did not ensure that the handling of requests and changes to repeat medicine were always carried out by clinicians. Processes for reviewing Patient Group Directives (PGDs) to ensure they remained in date were not effectively operated.</p> <p>The registered person did not ensure that relevant nationally recognised guidance were implemented and when appropriate new practices introduced.</p> <p>The registered person did not establish a system to enable the practice to gained assurance that appropriate recruitment checks have been carried out prior to commencement of employment.</p> <p>The registered person did not establish an effective system for clinical audit to assess, monitor and improve the quality and safety of services provided.</p>

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.</p> <p>How the regulation was not being met:</p> <p>The registered person did not ensure that medication reviews were carried out as part of, and align with, patients care and treatment plans. Patients in receipt of a medication, which required closer monitoring, had not been reviewed within recommended periods. For example, patients in receipt of medication used to treat high blood pressure, prevent blood clots, treat arthritis and mental health related disorders had not received a specific blood test within recommended time frames to check how well the medication were working.</p> <p>The registered person did not consult nationally recognised guidance relating to the delivering of safe care and treatment or implement this as appropriate. For example, we saw that some medicines that required closer monitoring were being prescribed outside of recommended guidelines.</p> <p>The registered person did not do all that is reasonably practicable to ensure compliance with relevant patient safety alerts. For example, the practice did not implement an effective system to ensure medicines alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA) were tracked and appropriate actions carried out in line with patient safety recommendations.</p> <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>