

Wyken Medical 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?		Inadequate	
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 Wyken Medical Centre on 24 February 2015. Overall, we rated the practice as inadequate.

Specifically, we found the practice to be inadequate for providing safe, effective, responsive and well led services. It was also inadequate for providing services for 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 and people experiencing poor mental health (including people with dementia). It was good for providing a caring service.

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

- Staff understood their responsibilities to raise concerns and to report incidents and near misses.

Information about some incidents was recorded but systems for monitoring, reviewing and learning from these were not fully developed to ensure that patient safety was maintained.

- There was no policy or structured guidance for staff to support and guide to ensure that patient safety was maintained.
- The practice had not identified and assessed all risks associated with the health, safety and welfare of patients and staff. Action plans were either not in place or had not been followed up.
- Patients were not protected from the risks of unsuitable staff being employed because recruitment policies and procedures did not ensure that the practice obtained all of the required information about new staff.
- Although the practice had carried out some limited audits in respect of patient care we saw no evidence of completed clinical audit cycles to support improvement in performance and improve patient outcomes.

Summary of findings

- Whilst the practice received national guidance there was no evidence that the practice was using this to review their clinical practice, share learning or improve outcomes for patients.
- Information about how to complain was available but the practice was not following its own policy in respect of responses to complaints.
- A high proportion of patients were unhappy with the practice's opening times and the availability of appointments. This was partly because the practice was only open in the mornings and closed at 1pm.
- The practice had insufficient leadership capacity and limited formal governance arrangements. They had introduced a number of policies and procedures to govern activity since 2013 but some did not reflect all of the relevant legislation and guidance and some had not been followed in practice.
- The practice had begun to hold a variety of meetings for clinicians and the whole staff team but these were not yet fully established.
- The practice had taken notice of views expressed by patients in national NHS patient surveys but had not proactively sought feedback from patients themselves.
- Patients said that the practice team provided attentive care which met their needs. They said they appreciated the fact that the staff knew them well. Patients told us staff were kind and treated them with compassion, dignity and respect.

The areas where the provider must make improvements are:

- Operate effective recruitment processes and ensure that the required information is available in respect of all staff employed to work at the practice.
- Ensure that effective arrangements for assessing, monitoring and improving the quality of the service at the practice are in place.
- Ensure that effective arrangements for identifying, assessing and managing risks to patients' and others' health, safety and welfare are in place, including arrangements to manage any disruption to the practice's ability to continue to deliver a service.
- Ensure that systems are in place to ensure that all clinicians are kept up to date with national and local

guidance and guidelines for the care and treatment of patients. This includes approaches for the care of patients at the end of life such as the Gold Standards Framework.

- Ensure that audits of practice are undertaken and that these include full clinical audit cycles.
- Ensure that learning from audits, significant events and complaints is taken into account in the assessment and delivery of care and treatment.
- Provide other services such as the out of hours primary care services and the ambulance service with information about patients at the end of life or whose health might deteriorate suddenly to help ensure their needs and wishes are properly considered and taken into account and their care planned and delivered accordingly.

In addition the provider should:

- Review the infection prevention and control policy to ensure it reflects current guidance and introduce systems for monitoring standards of general hygiene and cleanliness in the building. This should include a review of the work done so far in respect of precautions against legionella to ensure this is in line with guidance from the Health and Safety Executive.
- Ensure that all new staff receive a structured induction.
- Ensure that all staff are familiar with the requirements of the Mental Capacity Act 2005.
- Consider improving access for patients by reviewing the times that appointments are available and providing online services such as appointment booking.
- Develop a patient participation group to support the practice to work with the practice to improve services and the quality of care.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as inadequate for providing safe services. Staff understood their responsibilities to raise concerns and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Areas where we identified that the practice needed to improve were recruitment, infection control, anticipating events, management of unforeseen circumstances and dealing with emergencies. The practice had already started work on the areas that needed to improve but did not have an action plan to help them do this in a planned way. The practice addressed some of the areas we identified immediately.

Inadequate



Are services effective?

The practice is rated as inadequate for providing effective services. Data showed patient outcomes for some conditions were at or above average compared to national and local performance but below average for others. Staff were not aware of or using national guidelines to help them plan and deliver care and treatment. There were no completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. The practice team was small and this limited the scope of services which the practice could offer; however, they worked in partnership with other professionals including health visitors, district nurses and specialist services such as the diabetes retinal screening service and mental health teams.

Inadequate



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us they received attentive care which met their needs and they appreciated the fact that the staff knew them well. Patients confirmed that the GPs and other staff were kind and treated them with dignity and respect.

Good



Are services responsive to people's needs?

The practice is rated as inadequate for providing responsive services. The practice had an awareness of the needs of its local population based on local knowledge and familiarity with patients developed over a number of years. However, they had not carried

Inadequate



Summary of findings

out a comprehensive review of needs with a plan to secure any improvements needed. Patients were not happy with access to appointments; this was because the practice was only open in the mornings. The practice planned to introduce afternoon surgeries on two days a week. The practice was accessible to patients with restricted mobility but couches in treatment rooms were not adjustable to assist them. Information was available about how to complain but the processes for learning from complaints needed further development. The practice did not have a website or access to any on-line services.

Are services well-led?

The practice is rated as inadequate for being well-led. The GP had worked at the practice a long time but had only been legally responsible for the management of the service since September 2014 and had limited awareness of the scope of their duties. The practice manager was working hard to support the GP. They had also worked at the practice a long time but had only been the practice manager since July 2013.

The practice did not have a clear vision for the future. They were aware that they needed to consider this but had no firm plans for how they would manage this. The practice aimed to deliver a personalised service and to promote good outcomes for patients but this was not formalised in a long term business plan. The practice had had worked hard in the last 18 months to develop policies and procedures to govern activity and introduce staff meetings. They were aware that there was more work to be done. The practice did not have a patient participation group to support and work with them to improve services and the quality of care but did take note of the results of national patient survey results.

The practice's management processes had not identified a range of improvements that were needed. This was in part because the GP and practice manager were not aware of all the requirements of current legislation or of national guidance available to support them in the effective management of the practice.

Inadequate



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 practice is rated as inadequate for the care of older people. The practice did not have arrangements for ensuring that the care and treatment of older people always reflected current evidence-based practice. The practice informed us that 20% of their patients were over 65 and that there were no care homes within the area they covered. The GP and practice nurse provided home visits for those patients who were unable to come to the practice due to poor health or limited mobility. This included visits for annual health checks, flu vaccinations and medicines reviews or due to a specific health need. The practice offered flu vaccinations to patients who were carers and arranged for those unable to leave their home to have blood tests carried out at home and have prescriptions delivered by the local pharmacy.

Information was not routinely made available to out of hours and ambulance services to help ensure that patients at the end of their lives received the care and treatment they wished in the place of their choosing. The practice was not aware of the gold standards framework for end of life care but knew how many patients they had who were receiving palliative care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The provider is rated as good for caring overall and this includes for this population group. The provider is rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



People with long term conditions

The practice is rated as inadequate for the care of people with long-term conditions. The practice team was small and this limited the scope of services which the practice could offer. However, they worked in partnership with other professionals including health visitors, district nurses and specialist services such as the diabetes retinal screening service and mental health teams. Data for a number of long term conditions showed outcomes for patients were mixed. For example, the practice had achieved better than the national average for most aspects of diabetes care but was below the national average for chronic obstructive pulmonary disease (the name for a collection of lung disorders).

Information was not routinely made available to out of hours and ambulance services to help ensure that patients at the end of their

Inadequate



Summary of findings

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The provider is rated as good for caring overall and this includes for this population group. The provider is rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Families, children and young people

The practice is rated as inadequate for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice team knew local families well and liaised routinely with health visitors and school nurses. Appointments were not available outside of school hours because the practice closed at 1pm. The premises were suitable for families, children and young people because there was ample car parking and space in the practice for prams and pushchairs.

The provider is rated as good for caring overall and this includes for this population group. The provider is rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



Working age people (including those recently retired and students)

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The age profile of patients at the practice is mainly those of working age, young people but the services available did not fully reflect the needs of patients unable to go to the practice in the mornings. The practice closed at 1pm each day and did not provide early morning or evening appointments. The practice planned to introduce two early evening surgeries each week. The practice did not have a website and patients could not book appointments or order repeat prescriptions online. Health promotion advice was offered but patients had to go in person to the practice for this and the range of information was narrower than could be provided through a practice website.

Inadequate



Summary of findings

The provider is rated as good for caring overall and this includes for this population group. The provider is rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People whose circumstances may make them vulnerable

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice was situated in an area where there was some social and economic deprivation but had no homeless patients registered there. The practice team were aware of the pressures under which many of their patients lived, for example in respect of housing and employment issues. The practice had a very small number of patients with a learning disability and called them to have annual health checks.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They 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.

The provider is rated as good for caring overall and this includes for this population group. The provider is rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



People experiencing poor mental health (including people with dementia)

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). Available data showed that the practice had achieved good outcomes in respect of monitoring the physical health of these patients, including for example, cervical screening. The data showed that all of the practice's patients experiencing poor mental health had received an annual physical health check. The practice referred patients thought to have dementia to the local mental health team, but told us that patients experienced delays in obtaining appointments.

The practice referred patients with anxiety and depression to Improving Access to Psychological Therapies (IAPT) service. A counsellor from the service visited the practice regularly to see patients.

Inadequate



Summary of findings

The provider is rated as good for caring overall and this includes for this population group. The provider is rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 45 Care Quality Commission (CQC) comment cards that patients had filled in.

Information written by patients in the comment cards gave a generally positive picture of patients' experiences at Wyken Medical Centre. Most patients wrote that members of the practice team were friendly and caring and that they had received an excellent service at the practice. Some told us that they had been patients there for a long time and received attentive care which met their needs and appreciated the fact that the staff knew them well. Many of the comment cards confirmed that the GPs and other staff were kind and treated patients with dignity and respect.

Several patients told us that their GP had diagnosed a condition and provided them with the care and treatment they needed and others told us they had received attentive care in respect of a long term condition.

A quarter of the patients who completed a comment card were not happy with the practice's opening times and the availability of appointments. This was because the practice closed at 1pm. Some patients described situations when they needed to see a GP the same day but had to go to the local out of hours service or to accident and emergency department because no appointments were available at the practice. Several described that when they rang staff told them that no appointments were left. Three patients told us that they had had to wait a week for an appointment. Most were happy with their overall care but felt the practice needed to be open in the afternoons and some evenings.

Areas for improvement

Action the service **MUST** take to improve

- Operate effective recruitment processes and ensure that the required information is available in respect of all staff employed to work at the practice.
- Ensure that effective arrangements for assessing, monitoring and improving the quality of the service at the practice are in place.
- Ensure that effective arrangements for identifying, assessing and managing risks to patients' and others' health, safety and welfare are in place, including arrangements to manage any disruption to the practice's ability to continue to deliver a service.
- Ensure that systems are in place to ensure that all clinicians are kept up to date with national and local guidance and guidelines for the care and treatment of patients. This includes approaches for the care of patients at the end of life such as the Gold Standards Framework.
- Ensure that audits of practice are undertaken and that these include full clinical audit cycles.

- Ensure that learning from audits, significant events and complaints is taken into account in the assessment and delivery of care and treatment.
- Provide other services such as the out of hours primary care services and the ambulance service with information about patients at the end of life or whose health might deteriorate suddenly to help ensure their needs and wishes are properly considered and taken into account and their care planned and delivered accordingly.

Action the service **SHOULD** take to improve

- Review the infection prevention and control policy to ensure it reflects current guidance and introduce systems for monitoring standards of general hygiene and cleanliness in the building. This should include a review of the work done so far in respect of precautions against legionella to ensure this is in line with guidance from the Health and Safety Executive.
- Ensure that all new staff receive a structured induction.

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- Ensure that all staff are familiar with the requirements of the Mental Capacity Act 2005.
- Consider improving access for patients by reviewing the times that appointments are available and providing online services such as appointment booking.
- Develop a patient participation group to support the practice to work with the practice to improve services and the quality of care.

Wyken Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) inspector who carried out the inspection with a GP specialist advisor.

Background to Wyken Medical Centre

Wyken Medical Centre is situated on the outskirts of Coventry. It has around 2,100 patients. The practice is in purpose built premises. The practice has a free car park with disabled spaces nearest to the entrance. There is a pharmacy nearby.

The practice ownership changed during 2013 when one of two partners retired and the other took over the practice as a sole provider. The practice was subsequently re-registered with the Care Quality Commission (CQC) in September 2014. The GP told us that when they took over sole responsibility for the practice they had little experience of the governance, administration and financial aspects of managing a GP practice. This was because the retired partner had taken full responsibility for these aspects of running the practice. These were areas where they and the practice manager, also new to their role at that time, had needed to build their knowledge and experience together.

The practice has one permanent male GP who is supported by a male locum GP who routinely works at the practice two days a week. The practice has one practice nurse but does not have a female GP. The GPs and nurse are supported by a practice manager and two receptionists.

The practice does not have a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a Primary Medical Services (PMS) contract with NHS England but told us they were looking into the possibility of changing to a General Medical Services (GMS) contract.

Wyken Medical Centre does not have a practice website.

We reviewed information from a range of sources including Public Health England and the Health and Social Care Information Centre.

The practice does not provide out of hours services to their patients. When the practice closes at 1pm the practice phone diverts patients to an answering service run by Patient Care Services, part of the West Midlands Ambulance Service. This provides a recorded message telling patients to call the practice in surgery opening hours for appointments and prescriptions, to dial 999 for medical emergencies or to hold the line to speak with a member of the Patient Care Services team. The GP explained that this service transferred calls to them if a patient needed to be seen after 1pm but before the out of hours service was available. They said they often visited patients at home on these occasions.

When we planned this inspection we took into account information from the NHS England area team and Coventry Clinical Commissioning Group (CCG). They told us that they had concerns about limited access to the service due to the mornings only opening times.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Coventry and Rugby Clinical Commissioning Group (CCG) and the NHS England Area Team. We carried out an announced visit on 24 February 2015. We sent CQC comment cards to the practice. We received 45 completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with the principal GP, the locum GP, practice nurse, practice manager and two reception staff.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and said they would report incidents and near misses to the practice manager, GP or locum GP.

The practice had not had a system for recording significant events before 2013 and so had limited information available to demonstrate their record on safety before that date. The practice gave us details of significant events during the previous 12 months. These were all during January 2015. The staff confirmed that there had been none during 2014. However, in discussion with the GP and practice nurse we identified that there had been a significant event during 2014 that had not been correctly recognised and recorded.

Learning and improvement from safety incidents

The practice had begun to develop a structured system for reporting, recording and monitoring significant events, incidents and accidents but did not have a significant event policy. The practice had forms for recording significant events and had used these since 2013 following the appointment of the current practice manager. The practice manager had recently obtained an accident book. The practice had not previously had one for over four years. The practice manager told us that no accidents or near misses had occurred since they bought the book.

The GP and practice nurse spoke with us about an incident which had been the subject of a serious case review. A serious case review is a multi-agency forum which examines serious incidents in relation to the care of vulnerable children and adults to identify the root causes and lessons to be learned. They told us that the only outcome for the practice was that they were advised to have more regular meetings with the health visitor. The practice had not recorded this as a significant event and there was no record to show how the practice had ensured that any further internal learning or improvements were identified and acted upon. Similarly, situations relating to adult safeguarding matters had not been recorded as significant events.

The three significant events recorded were in respect of a prescribing error, a patient being taken ill at the surgery and a concern about a patient which the practice had referred to be dealt with under multi-agency safeguarding arrangements. The principal GP spoke with us about the prescribing incident. This had been recorded and the GP was able to talk through the relevant issues with us but had not established a clear process to ensure that a similar incident did not happen again. We noted that no actions had been recorded following the patient being taken ill at the practice. Staff had responded well to the event but the practice had not used the opportunity to review their arrangements for dealing with medical emergencies at the practice or to prompt them to consider the risks involved.

Staff were aware that the practice manager had forms to use to record incidents and that the practice had an accident book. However, their understanding was that the practice manager would complete the forms rather than them accessing these independently to complete as and when an event happened. Whilst significant events were discussed at staff meetings, these were not held often enough to provide structured opportunities for sharing learning from these with relevant staff.

The practice manager received national patient safety alerts and made the practice team aware of these and was aware that they now needed to report safety incidents using the national Central Alert Service (CAS).

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff told us that copies of all the practice's policies and procedures (including those about safeguarding), were available in paper form in the practice manager's office. Staff told us they were expected to read these and sign to confirm they had done so.

The GP was the lead for safeguarding vulnerable adults and children. They had completed safeguarding training at a suitable level to enable them to fulfil this role. All the staff we spoke with were aware this GP was the safeguarding lead and said they would not hesitate to raise any concerns they might have. The GP told us that they were always contactable even when not on duty at the practice.

Staff had received relevant role specific training about safeguarding, although one of the reception staff had not

Are services safe?

yet completed child safeguarding training. They told us we were booked in to do this in March 2015. Staff we spoke with were aware of situations which may need to be dealt with as safeguarding concerns and were confident that the GP would act if they alerted them to a concern. The reception staff said they would normally speak with the GP if they became aware of concerns and that the GP would deal with contacting other agencies such as the local safeguarding team. Information about relevant agencies was readily available at the practice. In addition to safeguarding training the practice nurse had also attended a training event about domestic violence.

The practice used the facility available on the computer system to highlight patients living in circumstances that made them vulnerable. This included children and young people with child protection plans and those in the care of the local authority. Older patients and those with long term conditions whose health might deteriorate suddenly were also highlighted using this system.

Our discussions with the practice nurse showed that they were aware of families where there were concerns and that they liaised with other agencies when necessary. For example, they were aware of young children in a family who may not have received necessary vaccinations. The nurse had liaised with a health visitor about this to ensure the family were contacted and provided with support and information about their children's health.

The team told us that they were aware of two situations involving older patients with dementia which were being dealt with within adult safeguarding arrangements. In one of these situations it had been the practice that had identified the concern and made the safeguarding referral.

The practice had a chaperone policy which the practice manager had reviewed on 1 February 2015. There were signs displayed at the practice to make patients aware that a chaperone service was provided when necessary. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The policy said that only a nurse or health care assistant should undertake chaperone duties and if not available the examination should be deferred. However, reception staff told us that they occasionally acted as a chaperone when this was necessary or requested by a patient. They had not completed chaperone training to equip them for this role. The practice manager told us that the clinical

commissioning group were running chaperone training shortly and said the staff would be booked to do this. They wrote to us on 27 February to confirm that non-clinical staff were booked to take complete this training on 17 June 2015. The practice manager confirmed that in the meantime only the practice nurse would act as a chaperone and that they would amend the policy once the non-clinical staff had completed their training.

Medicines management

No medicines were kept at the practice other than a limited range of emergency medicines in the GP's bag and in the nurse's treatment room. The GP checked the items in their bag weekly to make sure they had not expired. We checked medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The refrigerator was purpose designed for medicines storage and was about three years old and in good condition. We saw that it had been tested for electrical safety in January 2015.

We saw that the practice had records confirming that they checked the fridge temperatures to help make sure that medicines were always stored within the necessary temperature range. We noted that the refrigerator was plugged in to a wall socket. This was behind the refrigerator and so could not be accidentally turned off.

The practice nurse described their processes for checking that medicines were within their expiry date and suitable for use. We checked a sample with them and these were within their expiry dates. They showed us their records for monitoring the stock of vaccines. The records included delivery dates, dates the checks were completed and the details of each vaccine including the expiry date. The form included a column for recording the batch numbers. The practice had not been using this. The practice nurse said they would now start to do so. These records dated back for several years showing a history of monitoring and stock control and were updated each week.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. They showed us their folder containing these directions which were readily available in the practice nurse's room. The folder also contained additional information including national guidance about the specific type of meningitis vaccine that should be used for each age group. We saw that they were appropriately trained to

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administer vaccines and were informed that they would be going on an update course in March 2015. They told us they gained regular additional experience by working one evening each week as a bank nurse with an NHS vaccination team.

We found that the practice was not handling blank prescription forms in accordance with national guidance. They were not securely stored and the practice had no records to enable them to track the use of prescriptions. The practice manager made immediate arrangements to store these securely. On 27 February they wrote to confirm that they had put in place a stock control form to monitor prescription use and sent us a copy of this.

A prescribing support pharmacist employed by the clinical commissioning group visited the practice each week to look at prescribing arrangements at the practice. They had also provided a written repeat prescribing policy which the practice had adopted in July 2014. This was based on national guidelines. The GP told us that the practice had reduced antibiotic prescribing in line with local policy.

Cleanliness and infection control

We observed that the premises were visibly clean and tidy. The practice employed a cleaner who we briefly met. The cleaner told us that they did not have a written cleaning schedule or keep records of the cleaning they did but they knew the practice well and what was expected of them. Several patients who completed our comment cards said that the practice was always clean and hygienic.

The practice nurse was the lead for infection prevention and control (IPC). They had completed training provided by a specialist IPC nurse during 2012 and further training through the local NHS Trust during a mandatory training day in March 2014.

The practice had an infection control policy for staff to refer to. This was based on 2003 guidance from the National Institute for Health and Care Excellence (NICE) but did not refer to the Department of Health code of practice for infection prevention and control. The practice manager took the details of this so that they could order a copy for the practice. Information was displayed about sharps injuries and staff knew the procedure to follow if they injured themselves with a needle or other sharp instruments. The practice manager confirmed that they had no process for checking and recording the vaccination

status for each member of staff. When they wrote to us on 27 February 2015 they informed us that they had requested this information from the clinical staff so that they had this in their records.

We saw IPC audits carried out by the practice in February 2013 and November 2014. The audits identified areas for improvement including the flooring in treatment rooms, provision of suitable taps on treatment room hand basins and changing hand basins so that the drainage holes were not in direct line with the flow of water (which can result in splash back of stale water from the pipes). The practice did not have an action plan detailing when the work identified would be carried out. On the 13 March 2015 the practice manager informed us that a tradesman had been instructed to replace the hand basins and taps with ones suitable for use in treatment rooms.

We saw that there were notices about hand hygiene techniques in the staff and patient toilets. There were hand washing sinks with hand soap, hand gel and hand towel dispensers in treatment rooms. The practice had a plentiful supply of personal protective equipment. We saw that the practice had fabric curtains around the couches in the treatment rooms. The practice nurse told us that they made sure these were regularly washed but had not been keeping a record of this. They said they would start to do so immediately. We found that the practice did not have spillage kits to help them deal safely with any spillage of bodily fluids including blood, but confirmed in writing on 27 February that they had ordered these.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can contaminate water systems). Staff confirmed that the practice had not arranged for a legionella risk assessment to be carried out. No one at the practice was carrying out checks of the hot and cold water supply to reduce the risk of infection to staff and patients. The practice informed us in writing on 27 February that they had obtained a water testing kit from a specialist company. On 13 March they informed us that water samples had been sent for testing and that they had begun to draw up a risk assessment based on Health and Safety Executive guidelines for legionella.

IPC was discussed at staff meetings. For example, reception staff had been given guidance at a staff meeting about wearing disposable gloves when accepting sample bottles from patients.

Are services safe?

We saw evidence that the practice had suitable waste management arrangements with Coventry City Council for clinical, sharps and feminine waste and had secure storage for waste that was waiting to be collected.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The practice manager had recently arranged a new two year contract for maintenance and calibration of equipment used at the practice and we saw evidence that the company had recently been to the practice to do this.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy referred to several relevant pieces of legislation but not to the Health and Social Care Act 2008 (Regulated Activities Regulations 2010) and in particular Schedule three which relates to pre-employment checks. The practice also had a separate policy about checking the professional qualifications and registration of locum GPs and nurses. This clearly stated the importance of checking clinicians' professional registration with relevant organisations such as the General Medical Council, Nursing and Midwifery Council and Health and Care Professions Council.

We discussed staff recruitment processes with the practice manager. In respect of the locum GP they were able to show us that they had checked the GMC website and the NHS England area team performers list to assure themselves that there was no reason why they should not employ them. They had asked the locum to provide their criminal records check which the locum had told them was carried out in 2010. They had not received this yet. Following this discussion the practice manager recognised that as this check was over four years old it would be advisable to obtain an up to date check through the Disclosure and Barring Service (DBS). 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.

We confirmed that the practice had obtained recent DBS checks for all other members of the team. One of the non-clinical staff had started work at the practice several months before a DBS check was obtained and no structured recruitment checks had been carried out. This was because the practice knew the applicant and considered they had sufficient information about their conduct in their previous role. The practice manager was unaware of the staff recruitment requirements set out in Schedule three of the Health and Social Care Act 2008 (Regulated Activities Regulations 2010) or that these requirements applied to all new staff appointed even if known to the practice.

The practice had two GPs who were both part time – the GP registered with CQC as the service provider and a regular locum GP. The GP saw patients at the practice three days a week and the locum GP saw patients on the other two days. The GP carried out telephone consultations and home visits during the afternoons. We asked the GP about cover when they were on leave. They told us they rarely took time off but if necessary would arrange additional locum cover.

The practice nurse worked five hours each day from Monday to Friday. They were the only nurse directly employed by the practice. We asked about nurse cover when they were off sick or on leave. They told us that the practice had an informal arrangement with another local nurse who provided cover for them. This nurse also supported the practice with their annual checks for patients with chronic obstructive airways disease (COPD – the term for a range of lung disorders) because they were more experienced in this area than the practice nurse.

We learned from our discussions with the locum GP that they had not received an induction when they began working at the practice.

Monitoring safety and responding to risk

Since their appointment in July 2013 the practice manager had begun to establish systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. There was a health and safety policy but no risk register to provide an overview of any risks. The

Are services safe?

practice had prioritised the completion of IPC risk assessments and audits and a fire risk assessment but some other risks had not been assessed. These included risk assessments in respect of legionella and medical emergencies. On 13 March 2015 the practice manager confirmed that they had started work on both of these.

The practice told us that they were taking part in a funded NHS scheme to reduce unplanned admissions to hospitals and had begun working in partnership with a community matron to identify patients to include on their register for this. They had identified that the practice's highest accident and emergency attenders were patients between the ages of 18 and 25. They were looking at how to educate patients not to call 999 in non-emergency situations.

Arrangements to deal with emergencies and major incidents

Records showed that all staff had received training in basic life support during 2014. Staff told us that they did this together at the practice as a team. The practice did not have emergency equipment available in the event of a medical emergency at the practice. They did not have oxygen or an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

The practice had a limited range of emergency medicines available. We checked the available medicines with the nurse. We found that they had aspirin, glycerine tri-nitrate spray and adrenaline. These were for treating patients with symptoms of heart attack, angina and anaphylaxis respectively. We saw that the adrenaline was delivered to the practice on the morning of our inspection. The practice nurse said they thought the practice also had an inhaler to use if a patient had an asthma attack at the practice but was unable to find this.

The practice had not given consideration to what emergency medicines and equipment they might need and

had not completed a risk assessment to help them reach an informed decision about this. We asked whether the practice had any records of the emergency medicines kept at the practice. Staff confirmed they did not.

The practice manager wrote to us on 27 February 2015 to confirm that they were in the process of ordering emergency medicines kits, oxygen and face masks. On 13 March they informed us that they had carried out a medical emergencies risk assessment. On the basis of the risk assessment they had concluded that they did not need an AED.

The practice did not have a structured business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. However, staff told us that the practice was paired with another practice for support in providing patient care in the event of an emergency.

We saw that the practice had a health and safety policy but not a general risk log where any identified risks at the practice had been collated to provide an overview of risks and precautionary steps taken by the practice.

The practice manager had carried out a fire risk assessment. This had identified two fundamental risks which they had informed the principal GP about. These were the lack of a second exit from the building in the event that staff could not use the main entrance in a fire and the absence of a fire alarm system. On the basis of this assessment the practice manager had asked the fire service to carry out a more comprehensive fire risk assessment. This had not yet taken place. We established that fire extinguishers at the practice were checked annually by an external company and that staff received verbal instruction about fire procedures. We saw minutes of a staff meeting in February 2015 where this had happened and the practice manager told us that they were planning further fire training with another practice shortly.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We were not assured that clinical staff were familiar with current best practice guidance and guidelines from the National Institute for Health and Care Excellence (NICE). This was because the practice had no structured process for sharing this information when it was received and using it to improve patient care. There was no system at the practice to make sure that the GPs' and practice nurse's clinical practice was in line with NICE and other guidelines.

We discussed the assessment of the needs of the patient population with the GP and locum GP and learned that the practice did not have a formalised approach to this. Any understanding of the needs of different population groups served by the practice was based on the practice's perception of knowing patients as individuals rather than on measurable information. For example, the assessment of the needs of housebound patients was based on an annual review conducted by the practice nurse and GP. This review was based on a limited template which covered blood pressure monitoring and provision of flu vaccinations. There was no formal consideration of mental health, safety at home or carer contacts as possible additional topics for needs assessment.

Management, monitoring and improving outcomes for people

We found that the practice did not have a systematic approach to reviewing and adopting clinical guidelines including those from the National Institute for Health and Care Excellence (NICE). There was no system for reviewing these when they arrived. Neither the practice nurse nor the GPs could describe how they shared this information, learned from it and made sure that changes in clinical guidelines were introduced into day to day patient care and treatment.

The practice did not have evidence of having carried out completed clinical audit cycles and were unsure about how to establish an effective system for this. In advance of the inspection the practice sent us information about two clinical audits. One of these was about patients receiving vitamin B12 injections for pernicious anaemia and the other related to the prescribing of food supplements. Neither of these provided evidence of completed clinical audit cycles or showed how information gathered had

been used to improve patient outcomes. Neither audit made reference to relevant clinical guidance. For example, the vitamin B12 audit did not contain details of the normal range for blood tests against which to measure the effect of the treatment. Similarly the information in the other audit provided evidence that the practice knew which patients were prescribed nutritional supplements but did not contain any analysis of the effects on patients' well-being.

There was evidence to show that the practice carried out annual reviews for patient groups where this would be expected including those with long term conditions and older people. However, there was no process at the practice for reviewing or discussing the outcomes for patients either individually or overall.

The quality and outcomes framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions. The practice was aware of information collected for the QOF and in respect of some conditions had achieved the full amounts of points available. For example, during 2013/14 the practice had achieved full points for asthma, atrial fibrillation (a type of heart condition), cancer, heart failure, thyroid conditions and chronic kidney disease. They were above the national average in achieving the targets set for these conditions. We also noted from national data that the practice had achieved results above the national average for patients experiencing poor mental health. This related to the provision of annual health checks and specific checks such as cervical screening for women in that group. However, they were not using this information proactively to monitor outcomes for patients and were below or substantially below the national average for their achievements in respect of a range of other conditions. These included chronic obstructive pulmonary disease (COPD – the term for a range of lung disorders), diabetes and dementia.

The practice was not aware of the gold standards framework for end of life care but knew how many patients they had who were receiving palliative care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The GP reviewed patients with anxiety or depression within six weeks of prescribing medicines for this. They also

Are services effective?

(for example, treatment is effective)

referred them to the Improving Access to Psychological Therapies (IAPT) service and provided a room at the practice for IAPT counsellors to see patients from the practice.

The practice was aware of local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. In our discussions with the GPs we found that they had no action plan to use this information to help them improve and develop the service.

Effective staffing

The practice team included the principal and regular locum GP, a part time practice nurse working 25 hours a week, a practice manager and two part time receptionists. The practice had a staffing policy which looked at the necessary staffing levels for the practice. The reception staff and practice manager were able to provide sufficient cover between themselves for holidays and short term sickness when the policy stated that staffing rotas would be adjusted as necessary. The policy stated that in the event of longer absences the practice would employ temporary staff to provide the cover needed.

The staff training records showed that staff were up to date with attending safety related courses such as safeguarding and annual basic life support. One of the reception staff had completed a smoking cessation course to enable the practice to offer this service to patients. The practice manager and other staff confirmed that they received annual appraisals to support them in their role.

The principal GP had been revalidated during 2014. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice recognised that having only two GPs and one practice nurse limited the range of conditions that they could manage themselves. The practice nurse talked to us about the training they had done. They said they had completed training about asthma at diploma level and had attended updates since. They had also updated their vaccination and cervical smear training during 2014. They had completed some training about diabetes but not to diploma level. They told us they referred patients with diabetes whose treatment needs were complex to a

specialist diabetes nurse. Similarly, the practice referred patients taking medicines to prevent blood clotting to a specialist clinic as they did not have the expertise to support these patients themselves. The practice also arranged for patients with COPD to have their annual checks carried out by another nurse with expertise in these conditions.

The practice nurse told us that they attended practice nurse meetings held in the area about every two months. They explained that these were for a whole day and that the mornings were used for a meeting and the afternoons for training. They explained that they also worked for NHS Professionals which is the name for the NHS staff bank. This involved working with a vaccination team one evening each week carrying out vaccinations for school age children. They received protected learning time to enable them to maintain their continued professional development.

The locum GP used by the practice worked there two mornings every week to provide continuity of care for patients. The practice had carried out checks to confirm that they were currently registered with the General Medical Council and were on the performers list with NHS England.

Working with colleagues and other services

The team described working closely together to communicate about patients' care and treatment needs. This was apparent on the day of the inspection when they had to deal with some situations that needed their immediate attention.

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP or locum GP (depending on the day) was responsible for checking the information and initiating the action required. All staff we spoke with understood the part they played in this process and emphasised that communication was good because the practice team was small.

The practice took part in monthly multidisciplinary team meetings with district nurses and community matrons to discuss the needs of patients needing support at home.

Are services effective?

(for example, treatment is effective)

These included patients with complex needs who required help to manage their conditions and those at the end of life. Staff told us that the meetings were about to be reduced to three monthly.

The practice also met monthly with the local health visitor to discuss children known to be at risk and those in the care of the local authority.

The practice worked in partnership with the Improving Access to Psychological Therapies (IAPT) team and provided a room regularly for a counsellor to see patients from the practice.

The practice knew that they had 13 patients with a diagnosis of dementia. They worked with staff from the local mental health team to ensure those patients had an annual health check and a plan for their care. The practice team told us they experienced some difficulties in accessing this service due to delays in patients receiving appointments.

Information sharing

The practice had a system for checking, recording and storing information sent to them by other health professionals including the out of hours service. The reception team were not aware of the practice having any system for sharing information about patients at the end of life with the out of hours or ambulance services. The practice manager confirmed that the practice did not have a formal system for this and relied on contact patients would have with the district nurse or palliative care teams to liaise with hospitals and the ambulance service. This, together with the absence of patient care plans could result in patients not having their wishes regarding their care and treatment fulfilled.

The practice informed us that they used the Choose and Book system for the majority of their referrals and during the last three months of 2014 had used the system 136 times. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice was using the electronic Summary Care Record and confirmed that they had contacted all patients in writing to inform them about this system and to give

them the opportunity to opt out of this if they wished to. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Patients confirmed that the practice kept them up to date about test results and contacted them promptly if they needed to come in to see the GP or practice nurse about these.

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

We found that the GPs and practice nurse had limited awareness of the MCA and their duties in fulfilling it. The practice nurse told us that she recalled that it was mentioned when they did their safeguarding training but confirmed that they had not had specific training about this and was not aware of the Mental Capacity Act code of practice. They told us that when seeing a patient they would not proceed if they were unsure that the patient understood the reason for their appointment or what the nurse was going to do. The practice manager asked for the details of the MCA code of practice so that they could order a copy for the practice.

The Gillick competence test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The practice nurse was familiar with Gillick Competence and said they regularly needed to consider this when they worked with the vaccination team as a bank nurse. They gave us examples of situations where they had needed to use this and showed us a form they used to record decisions they made.

Health promotion and prevention

The practice was limited in its ability to provide extensive health promotion services due to the size of the practice, skill mix of the clinical team and the opening hours. However, the practice team worked within its capacity to provide as many services as possible.

All new patients registering with the practice were booked to see the practice nurse for a health and medicines check. All patients between the ages of 40 and 65 were offered

Are services effective?

(for example, treatment is effective)

NHS health check appointments with the practice nurse. Patients due for medicines reviews and routine blood pressure checks were telephoned to remind them to book an appointment.

The practice nurse carried out cervical screening and in 2014/15 national data showed that they had fully met the expected target for this preventative procedure.

Available data showed that overall the practice's performance against aspects of care and treatment measured nationally was variable. In some aspects of care and treatment the data showed the practice was performing above the national average whilst for others it was below or significantly below. This suggested an opportunistic rather than a planned approach to health promotion.

The practice had a very small number of patients with a learning disability and confirmed that all were offered an annual physical health check. Older patients were supported to manage their medicines effectively because

the practice worked in partnership with the local pharmacy to arrange for medicines to be delivered. The practice also arranged for the pharmacy to dispense medicines in easy to use containers.

The practice carried out full health checks on the same days as the retinal screening service bus visited the practice so that patients could have all their checks on the same day.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was also providing a phased programme of shingles vaccination for patients based on their ages.

The practice carried out chlamydia screening if patients asked for this.

One of the reception team had completed smoking cessation training and had begun to see patients. They were enthusiastic about this new role and were looking forward to developing this service at the practice. They received external supervision from the Coventry Healthy Lifestyles Service to support them with this.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed information provided by the practice about the GP patient survey data published on 8 January 2015. This showed that 87% of patients who had completed a survey said that their overall experience of using the surgery was very good or fairly good, 89% said that their GP was very good or good at giving them enough time and 91% said their GP listened to them.

Patients completed Care Quality Commission CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and the majority were positive overall about how they were treated by staff at the practice. Some patients had recently joined the practice while several told us they had been patients for many years. New and long term patients were equally positive in their views. Patients described the practice team as helpful, friendly and respectful. They told us that their GP did not rush them and treated them with consideration.

Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We observed staff kept the doors to consultation and treatment room doors closed when seeing patients and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy and staff were aware of the importance of maintaining patients' privacy. For example, the practice manager and one of the reception staff told us they lived nearby and were very careful about conversations outside work. Both confirmed that they would always explain politely that they could not discuss anything about patients or the practice. The reception desk and telephones were situated so that telephone calls could not be overheard.

Care planning and involvement in decisions about care and treatment

We looked at the GP patient survey information published in January 2015. This showed that most patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 87% said their GP was good or very good at explaining tests and treatments and 77% said their GP was good or very good in involving them in decisions about their care.

Patient feedback on the comment cards we received was also positive and those that commented on this aspect of their care gave examples of their GP explaining things to them, keeping them informed and taking prompt action.

Staff told us that translation services were available for patients who did not have English as a first language although they rarely needed to use this. The practice nurse gave us two examples when they had arranged for patients to have interpreters to make sure that they would understand everything said to them.

Patient/carer support to cope emotionally with care and treatment

A few patients included specific information on our comment cards about the support and attentive care they had received. Patients described receiving support and kindness during difficult circumstances and appreciated being treated as an individual.

The staff gave us an example of providing support to vulnerable patients. These involved responding to requests to see specific team members and being flexible about how soon they were seen.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

On the day of our inspection we saw direct evidence of the practice team responding in a compassionate way to two families in distressing circumstances. It was evident that the team knew the individuals well and wanted to do all they could to support them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice informed us that 20% of their patients were over 65 and that there were no care homes within the area they covered. There were 196 patients aged between 65 and 74 and 240 were over 75. The GP and practice nurse provided home visits for those patients who were unable to come to the practice due to poor health or limited mobility. This included visits for annual health checks, flu vaccinations and medicines reviews or due to a specific health need. The practice offered flu vaccinations to patients who were carers and arranged for those unable to leave their home to have blood tests carried out at home and have prescriptions delivered by the local pharmacy.

The practice knew that they had 13 patients with a diagnosis of dementia. They worked with staff from the local mental health team to ensure those patients had an annual health check and a plan for their care. The practice told us they had two patients with learning disabilities and provided annual health checks for them.

Patients with cancer or at the end of life due to other conditions were highlighted on the practice computer system. This made staff aware to give them priority if they or their family called for an appointment or home visit.

The practice told us they had 109 patients with diabetes. Each July the retinal screening service bus came to the practice three times to carry out checks of patients' eyes. The practice informed us that on those days the GP and practice nurse also carried out other annual health checks that patients with diabetes needed. These included foot pulse checks, medicines reviews and dietary reviews. Arrangements were made for patients to be booked to go to the nearest hospital for their routine blood tests which the practice did not carry out. They did this to provide a convenient opportunity for patients to have the full range of tests they needed on the same day.

Staff highlighted to us that they were aware that the couches in the treatment rooms were not adjustable and that they were not easy for some patients to get on to. They hoped to provide adjustable ones at some stage but currently one patient needed to go to another NHS location for certain examinations.

The GP told us they routinely carried out home visits during the afternoons provided a patient made a request before 12pm. They also provided telephone consultations during the afternoon where this was appropriate.

Tackling inequity and promoting equality

The practice team were aware of the make-up of the local population which included people from diverse communities. The practice team told us that most patients spoke English well and whilst they had access to interpreter services they rarely needed to use this. One patient specifically highlighted in a comment card that the practice respected all their patients and provided care equally regardless of race. The practice nurse gave us two examples of arranging interpreters for families who could not easily communicate using English.

Since 2013 the practice had improved access to the building for patients with limited mobility or who used wheelchairs. This had involved installing a ramp and handrails at the entrance to the practice. The practice had its own car park with spaces close to the entrance. We saw that the waiting area was large enough for patients with wheelchairs and prams. The building was a single storey which meant that all rooms were accessible to patients. Accessible toilet facilities were available for patients attending the practice.

The practice did not have an induction hearing loop to assist patients who used hearing aids.

Staff told us that the practice did not have any homeless patients or traveller families registered with them but would respond as needed when necessary.

Access to the service

The NHS England Area Team and Coventry and Rugby Clinical Commissioning Group (CCG) told us they were concerned about access to the practice because it was closed in the afternoons. Data available from Public Health England showed that 42.7% of patients were satisfied with the practice opening hours compared with the national average of 76.9%. A quarter of the 45 patients who completed one of our comment cards were unhappy with the practice's opening times and the availability of appointments. The practice closed at 1pm so no appointments were available outside school hours for children and young people or at times that suited patients with day time commitments. These concerns were also

Are services responsive to people's needs?

(for example, to feedback?)

reflected in the GP patient survey data published in January 2015 when 40% of patients said the practice was not open at times convenient for them. Only one patient wrote in a comment card that they found it difficult to get through to the practice by telephone. This was consistent with the January 2015 patient survey data we looked at which showed that 81% of patients found it very or fairly easy to do so.

Some patients described situations when they had needed to see a GP the same day but had to go to the local out of hours service or to accident and emergency department because no appointments were available at the practice. Several described that when they rang staff told them that no appointments were left. Three patients told us that they had had to wait a week for an appointment. Most were happy with their overall care but felt the practice needed to be open in the afternoons and some evenings.

Appointments were available from 9.30am to 12.50pm on weekdays. Telephone consultations were available with the GP when the practice closed at 1pm. The reception team showed us that some appointments were kept free each day to enable the practice to offer same day appointments. We saw that appointments were still available on the day we inspected and on other days in that week. We asked staff why patients might have had to wait a week for an appointment. They said that this would normally happen if they were asking to see the principal GP who did not see patients every day. They also explained that the blocked same day appointments were for patients who needed to be seen on the day they asked for an appointment because it was for an urgent need. Those who did not need to be seen urgently might therefore have to wait until a day when pre-bookable appointments were available.

Staff told us that while most appointments were booked for 10 minutes, patients could request longer appointments if necessary.

The practice had accepted that whilst most patients were happy with the service overall many were not satisfied with the practice's opening hours. They told us they were planning to improve access to appointments by introducing afternoon surgeries from 4pm to 6pm two days a week. This was in response to NHS England Area Team's concerns and comments in the national patient survey and the NHS Friends and Family test.

The practice did not have a website or arrangements for online booking. Patients needed to phone or visit the practice to make appointments and obtain information such as how to arrange urgent appointments and home visits.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed. When the practice closed at 1pm the practice phone diverted patients to West Midlands Ambulance Service's patient care services. This provided a recorded message telling patients to call the practice in surgery opening hours for appointments and prescriptions, to dial 999 for medical emergencies or to hold the line to speak with a member of the patient care services team. The GP and practice manager told us that patients who spoke with one of the patient care services team were transferred to speak to the practice GP. The GP told us that they provided on-call cover from 8am to 8.30am and from 1pm to 6.30pm. After 6.30pm patients phoning the practice were connected with the NHS 111 service.

Home visits were available for patients too unwell to go to the practice and those whose mobility made this difficult for them. The GP told us that they routinely visited patients at home and that during February 2015 they had already made 30 visits to patients in their own homes.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager and the GP shared the lead responsibility for all complaints in the practice.

We found that the practice had received very few formal complaints but that a number of patients had raised concerns about access to appointments and the practice opening hours. We looked at records for three complaints received since the practice manager was appointed in July 2013. We saw a letter that the practice manager wrote to a patient about a complaint in 2013 and saw that this was a polite, friendly and non-defensive response to the patient's concern. We found that this was the only written response made to a patient raising a concern. This was not in line with the practice complaints policy which informed patients that they would receive a written acknowledgement and response. However, we saw that in

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

each case the practice had responded verbally to the patients who had raised concerns and had shared learning about the three issues with other members of the practice team.

The practice did not have a process to carry out reviews of complaints to detect themes or trends but we saw

evidence that the practice had discussed all the complaints received during the last year with staff. The main source of concerns from patients related to access to appointments. The practice was planning to extend their opening hours to provide appointments twice a week from 4pm to 6pm.

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

The principal GP had become a partner at the practice in 1995 and took over as the sole GP in 2013. They did not have a clear vision for the future of the practice. They were over 65 but were not yet ready to retire completely. This was why they worked part time. They were aware that they needed to consider the longer term future of the practice but did not yet have firm plans for how they would manage this.

The practice aimed to deliver a personalised service and to promote good outcomes for patients but this was not formalised in a long term business plan.

Governance arrangements

During the inspection we identified a number of areas where the practice needed to make improvements. It was positive that they took immediate action in respect of several of these. However, we were concerned that the practice's own management and systems had not identified these and that the practice had not taken action to make improvements. This was in part because the GP and practice manager had not been aware of some of the requirements of current legislation or national guidance available to support them in the effective management of the practice.

The principal GP explained to us that when they took over the practice on their own in 2013 they had little experience of the administrative and financial aspects of managing a GP practice. These were areas where they had to work with the practice manager, also new to their role at that time, to build their knowledge and experience together.

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a policy file in the practice manager's office. We saw that all of the policies had been developed during the last 18 months by the practice manager. They told us that before they were appointed to the post in 2013 there were very few structured policies, procedures and records at the practice. They had needed to build all of the necessary management and governance structures and were aware that there was more work to be done.

The locum GP was not aware of any of the practice's policies and we learned from the principal GP that the practice did not have any written clinical policies.

The practice used the Quality and Outcomes Framework (QOF) but was not actively using this to measure its performance. The QOF data for this practice showed it was performing in line with national standards in respect of some of the areas included in the scheme but were below the national average in others. The practice did not have a structured process for discussing QOF data at practice meetings.

The practice did not have an organised programme of clinical audits to help the clinical team monitor quality and systems to identify where action should be taken.

The practice had some arrangements for identifying, recording and managing risks but did not have a comprehensive risk log which identified a full range of potential issues.

The practice did not hold meetings often enough for these to provide an effective framework to support governance arrangements at the practice.

Leadership, openness and transparency

In discussion with the principal GP and practice manager we learned that neither had had extensive management or leadership experience or training. The GP had worked at the practice since 1995 and had taken over the practice on their own when their GP partner had retired in 2013. The retired partner had held all financial and administrative responsibility themselves. This meant that when the GP took over they had limited awareness of the work involved in having sole responsibility for the running of a modern GP practice. The practice manager had worked at the practice since 2006 as a member of the reception team. When they took over as practice manager in July 2013 they had needed to teach themselves everything that was involved in the role. There were no plans for them to complete formal training in respect of practice management to support them to develop additional knowledge and skills to carry out this role.

Various staff meetings took place but these were not frequent. We saw that the practice manager, practice nurse and principal GP held meetings in December 2014 and

Are services well-led?

Inadequate 

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

October 2014. A full team meeting was held in October 2014 and another in February 2015. This limited the number of opportunities for information sharing and team learning within the practice.

The practice manager was responsible for the policies and procedures at the practice. They explained to us that when they were appointed there were few structured policies in place and they had needed to develop those that now existed over the last 18 months. They said they had done this with limited outside support or practical assistance.

All the staff we spoke with told us that the practice was friendly and that the team worked together well. The staff team were very positive about the GP as a caring employer.

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

There was a suggestions box in the waiting room for patients to use but the staff said that no comments had been received for at least four months. The practice had looked at feedback from patients through the national patient survey and the NHS Friends and Family test. Through this they had identified that whilst most patients were happy with the service many were not satisfied with the practice's opening hours. The practice told us that as a result of this and NHS England Area Team's concerns they were making plans to open between 4pm and 6pm on two evenings each week.

The practice did not have a patient participation group (PPG) and had no immediate plans to establish one although the practice manager told us that the clinical commissioning group had advised them of the benefits of this.

The GP and practice manager told us that they encouraged staff to go to them about any concerns they might have. The GP told us that they tried to have monthly staff meetings to discuss staff problems, significant events and complaints but there was no evidence that they had been held this often.

All of the staff we spoke with confirmed that the GP and practice manager listened to them and treated them with respect.

The practice had a whistleblowing policy which but some of the staff we spoke to were not aware of this. However, all the staff told us they would not hesitate to raise concerns about the practice and the treatment of patients.

Management lead through learning and improvement

The GP informed us that appraisals for the non-clinical staff were carried out by the practice manager.

The practice nurse told us that the principal GP was very supportive about releasing them for training events. This included arranging for another local nurse to provide cover when this was needed. They told us that the principal GP had carried out an appraisal with them during February 2015. The practice manager and other staff confirmed that they received annual appraisals to support them in their role.

Staff we spoke with were positive about learning opportunities and about improvements at the practice. One member of the team told us that the GP and practice manager had made improvements in the last year. The practice had arranged more training, they were more aware of what was happening and practice meetings were more regular. The practice manager informed us that they had started to attend training arranged through the local NHS Trust. This was aimed at practice managers and took place one day a month.

We found that there was some discussion of significant events and complaints with staff but we were not confident that the practice had a clear understanding of the range of issues that may need to be considered. The GP and practice nurse spoke with us about an incident which had been the subject of a serious case review. A serious case review is a multi-agency forum which examines serious incidents in relation to the care of vulnerable children and adults to identify the root causes and lessons to be learned.

They told us that the only outcome for the practice was that they were advised to have more regular meetings with health visitor. The practice had not recorded this as a significant event and there was no record to show what, if anything they had learned and whether they had made any changes or improvements as a result. When we discussed the incident with staff they did not tell us of any improvements or changes they had made.

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 Treatment of disease, disorder or injury	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>We found that patients were not protected because the provider did not have effective recruitment procedures to reduce the potential for unsuitable people gaining employment.</p> <p>This was in breach of regulation 21 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>We found that the provider was not protecting patients and others against the risks of unsafe or inappropriate care and treatment because they were not –</p> <ul style="list-style-type: none">• Regularly assessing and monitoring the quality of the service provided at the practice and identifying areas for improvement in a timely way.• Ensuring that effective arrangements for identifying, assessing and managing risks to patients and others health, safety and welfare were in place.• Taking into account incidents that resulted in or had the potential to result in harm to patients or the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies such as the National Institute for Health and Care Excellence.• Had no arrangements in place to manage any disruption of their ability to continue to provide a service such as (for example) fire, power failure, staff shortages.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Treatment of disease, disorder or injury

Regulation

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

The practice was not ensuring that patients at the end of life or whose health might deteriorate suddenly would have their needs and wishes properly considered and taken into account and their care planned and delivered accordingly when the surgery was closed because they did not provide out of hours primary care services and the ambulance service with information about those patients.

This was in breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.