# Dr Sergio De Cesare

## 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? | Requires improvement |
| Are services responsive to people's needs? | Requires improvement |
| Are services well-led? | Inadequate |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Dr Sergio De Cesare on 4 and 10 January 2017, the inspection was carried out over two days to ensure that all key practice staff members were available to contribute to the inspection. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment, the locum nurse was administering vaccinations without Patient Group Directions and actions including infection control audits and legionella testing had not been carried out.
- The practice had no policies or protocols to govern activity.
- There was no process for acknowledging and acting on patient safety alerts.
- Staff were not clear about significant events, reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- Patient outcomes were limited as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There was insufficient detail paid to safeguarding, non-clinical staff had not been trained and could not demonstrate they understood their responsibilities to report concerns and were confused about who the lead in the practice was. There was also no protocol.
- Non clinical staff had no training appropriate to their roles and staff members had not received an appraisal or personal development plan. No staff

# Summary of findings

members including clinical staff had received fire safety training and there was no fire risk assessment, no fire alarm testing or fire drills and fire extinguishers were last tested in October 2015.

- There was no failsafe mechanism for monitoring cervical cytology results.
- The practice did not make use of an interpreting service.
- The practice did not have a patient participation group and little attention was paid to gathering feedback from patients.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Appointment systems were not working well so patients did not receive timely care when they needed it.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Introduce effective processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Implement systems and processes to mitigate risks associated with infection control and legionella testing.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure Patient group directions are in place for any nurse working in the practice that give vaccines or immunisations.
- Identify and mitigate risks to patients safety ensuring the proper and safe management of medicines, that equipment used by the practice is safe and in good working order and risks associated with cold chain maintenance is mitigated.
- Introduce systems to ensure all clinicians are kept up to date with national guidance and guidelines.
- Consider a programme of clinical quality improvement such as the introduction of clinical audits, including re-audits to ensure improvements have been achieved.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Introduce and maintain a comprehensive and up to date business continuity plan, with copies available off site.
- Implement a failsafe mechanism for monitoring cervical cytology results.

The areas where the provider should make improvement are:

- Review systems for identifying carers to ensure appropriate support is provided to them.
- Consider using an interpreting service to allow patient choice over whether they use family or friends as an interpreter.

Following the inspection on 10 January 2017 urgent action was taken to suspend the practice for six months.

I am placing this service in special measures.

Services placed in special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or varying the terms of their registration within six months if they do not improve.

# Summary of findings

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

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

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. Areas of concern found were in safeguarding, recruitment, infection control, medicine management, anticipating events, management of unforeseen circumstance, dealing with emergencies and governance.
- Staff were not clear about the process for reporting significant and incidents and there were no policies or protocols to support this. The practice could not demonstrate how learning and outcomes of events were communicated and shared.
- There was insufficient attention to safeguarding children and vulnerable adults as there was no policy in place for staff to follow. Non-clinical staff had no safeguarding training and were unable to demonstrate that they understood their responsibility to report concerns.
- Staff members who acted as chaperones were not trained for the role and had not received a Disclosure and Barring Service (DBS) check and there was no risk assessment in place to mitigate against the risk of this.
- The regular locum practice nurse administered vaccines without the use of patient group directions (PGD's).
- The cold chain was not maintained, fridge temperatures had not been monitored since October 2015 and so we could not be assured that vaccines were stored in line with the manufacturer's guidelines.
- There had been no infection control audit and legionella testing had not been carried out.
- There was no process for checking equipment (including emergency equipment) was in good working order and fit for purpose, we found that the defibrillator battery was low and needed changing and out of date equipment such as syringes, needles and swabs.
- There was no fire risk assessment, fire alarms were not tested, there were no fire drills and the fire extinguishers were last tested in October 2009.
- There was no failsafe system mechanism for cervical cytology and there was no monitoring of inadequate tests.

# Summary of findings

**Are services effective?**

**Inadequate**

The practice is rated as inadequate for providing effective services and improvements must be made.

- Patient outcomes were limited as little or no reference was made to audit or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There was minimal engagement with other providers of health and social care professionals.
- There was no staff appraisal system and no support for any training that was required.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were sometimes lower than the CCG and national averages, but there was high exception reporting in some domains

**Are services caring?**

**Requires improvement**

The practice is rated as requires improvement for providing caring services.

- The practice did not offer a translation service; patients were expected to bring a family member or friend to their appointment to act as a translator.
- The practice had identified less than 1% of patients as a carer and minimal information was available to them to advice of services available to them.
- Information about services was limited.
- Data from the national GP patient survey showed patients rated the practice positively for care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

**Requires improvement**

The practice is rated as requires improvement for providing responsive services.

- The practice had not reviewed the needs of its local population in the last three years.
- Although the practice had a large number of working age patients and offered extended opening hours for appointments on a Monday morning, patients could not book appointments or order repeat prescriptions online.

# Summary of findings

- There was no complaints policy, procedure or complaints form for patients to complete and information about how to complain was very limited.

**Are services well-led?**

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a vision but not all staff were aware of this and their responsibilities in relation to it.
- There was a leadership structure and staff felt supported by management, however not all staff were aware of which staff led in which areas, for example reception staff were unaware that the GP was the safeguarding lead.
- The practice had no policies or procedures to govern any activity in the practice.
- There was no formal or documented induction process and no staff members had received an appraisal or had a personal development plan in place.
- Non-clinical staff had not received any training relevant to their role including fire training.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- The practice told us that they carried out practice meetings; however these were not documented, there were no agenda, minutes or noted actions for improvements to be made.
- The practice did not have a business continuity plan and had not identified a buddy practice to be used if the premises were not accessible.

# 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

**Inadequate**

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

- For those patients with the most complex needs, the named GP did not work with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- The practice did not participate in the unplanned admissions initiative, which aimed to keep older patients out of hospital and well at home.

### People with long term conditions

**Inadequate**

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

- The GP had the lead role in chronic disease management but patients at risk of hospital admission were not identified.
- Patients had a named GP and a structured annual review to check their health and medicines needs were being met. However there was no structured recall system to ensure that all required patients would be invited for an annual review.
- For those patients with the most complex needs, the named GP did not work with relevant health and care professionals to deliver a multidisciplinary package of care.
- Performance for diabetes related indicators was lower than the national average.For example, the percentage of patients on the diabetes register with a record of a foot examination and risk classification within the preceding 12 months was 79% compared with the national average of 88%.
- Longer appointments and home visits were available when needed.

### Families, children and young people

**Inadequate**

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

# Summary of findings

- There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk.
- Immunisation rates were comparable to CCG and slightly lower than the national averages. For example, childhood immunisation rates for the vaccinations given to five year olds from 65% to 92% compared to the CCG averages of 66% to 89% and the national averages of 88% to 94%.
- The practice nurse administered immunisations without the use of Patient Group Direction's.
- Appointments were available outside school hours.
- The practice's uptake for the cervical screening programme was 75%, which was below the CCG average of 78% and the national average of 82%. There was no policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice could not demonstrate how they encouraged uptake of the screening programme. There were no failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme, but the practice followed up women who were referred as a result of abnormal results. However the practice did not monitor inadequate cervical cytology rates.

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

**Inadequate**

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

- The practice had a large number of working age, students and the recently retired but the services available did not fully reflect the needs of this group.
- Although the practice offered extended opening hours for appointments on a Monday morning, patients could not book appointments or order repeat prescriptions online.
- Health promotion advice was offered but there was limited accessible health promotion material available through the practice.

**People whose circumstances may make them vulnerable**

**Inadequate**

The provider was rated as inadequate for safety, effectiveness and for well-led and requires improvement for caring and responsive.

# Summary of findings

The issues identified as inadequate overall affected all patients including this population group. There were no policies or arrangements to allow people with no fixed address to register or be seen at the practice.

- The practice held a register of patients with a learning disability and had carried out annual health checks for them, but there was no evidence that these had been followed up.
- Not all staff knew how to recognise signs of abuse in vulnerable adults and children.
- Not all staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Inadequate

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

- The practice identified patients
- The practice had not worked with multi-disciplinary teams in the case management of people experiencing poor mental health.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented in the record was 62%, which was lower than the CCG average of 91% and the national average of 88%.
- The practice did not carry out advance care planning for patients with dementia.
- The practice informed patients experiencing poor mental health about support groups or voluntary organisations.
- The practice did not have a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.
- The practice had not carried out training on how to care for people with mental health needs and no dementia training was available.
- The GP administered injectable medicines for patients with mental illness but there was no system in place to follow up non-attenders.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results below show the practice was performing above local and national averages. Three hundred and fourteen survey forms were distributed and 101 were returned. This represented 3% of the practice's patient list.

- 87% of patients found it easy to get through to this practice by phone compared to the CCG average of 66% and the national average of 73%.
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 82% the national average of 76%.
- 93% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 93% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 82% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards which were all positive about the standard of care received. There was a recurring theme of friendly and caring staff.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

## Areas for improvement

**Action the service MUST take to improve**

The areas where the provider must make improvements are:

- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Introduce effective processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Implement systems and processes to mitigate risks associated with infection control and legionella testing.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure Patient group directions are in place for any nurse working in the practice that give vaccines or immunisations.
- Identify and mitigate risks to patients safety ensuring the proper and safe management of medicines, that equipment used by the practice is safe and in good working order and risks associated with cold chain maintenance is mitigated.
- Introduce systems to ensure all clinicians are kept up to date with national guidance and guidelines.
- Consider a programme of clinical quality improvement such as the introduction of clinical audits, including re-audits to ensure improvements have been achieved.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Introduce and maintain a comprehensive and up to date business continuity plan, with copies available off site.
- Implement a failsafe mechanism for monitoring cervical cytology results.

# Summary of findings

**Action the service SHOULD take to improve**

The areas where the provider should make improvement are:

- Review systems for identifying carers to ensure appropriate support is provided to them.
- Consider using an interpreting service to allow patient choice over whether they use family or friends as an interpreter.

# Dr Sergio De Cesare

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector supported by a GP specialist adviser.

## Background to Dr Sergio De Cesare

Dr Sergio De Cesare is located in a converted terraced house on the borders of Barnet and Haringey and is a part of Barnet Clinical Commissioning Group (CCG). The practice has good transport links and there is free parking on the surrounding roads.

There are 3300 patients registered at the practice, 40% of patients have a long term condition which is lower than the CCG and national averages of 49% and 54%, the practice also has a larger number of patients in paid work or full time education than the national average at 78% compared to the CCG average of 66% and the national average of 62%. Eleven percent of the practice population is aged over 65; this is lower than the CCG average of 14% and the national average of 17%.

The practice has one principal male GP who carries out 9 sessions per week and a regular locum female nurse who carries out two sessions per week over two days. There is a practice manager and two reception/administration staff members.

The practice operates under a General Medical Services (GMS) contract (a contract between NHS England and general practices for delivering general medical services and is the most common form of GP contract).

The practice is open Monday to Friday between 8am and 6:30pm except Thursdays when the practice closes at 1pm to complete administration tasks. The practice has morning extended hours appointments on a Monday, phone lines are answered from 8:30am and appointment times are as follows:

- Monday 7:30am to 8am, 9am to 11am (face to face), 11am to 1pm (telephone consultations), 3pm to 5pm (face to face) and 5pm to 6pm (telephone consultations).
- Tuesday, Wednesday and Friday 9am to 11am (face to face), 11am to 1pm (telephone consultations), 3pm to 5pm (face to face) and 5pm to 6pm (telephone consultations).
- Thursday 9am to 11am (face to face), 11am to 1pm (telephone consultations).

The locally agreed out of hours provider covers calls made to the practice whilst it is closed.

Dr Sergio De Cesare operates regulated activities from one location and is registered with the Care Quality Commission to provide family planning, surgical procedures, treatment of disease, disorder or injury, maternity and midwifery services and diagnostic and screening procedures.

## Why we carried out this inspection

We inspected this service as part of our comprehensive programme. This location had not previously been inspected.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 and 10 January 2017. During our visit we:

- Spoke with a range of staff including a GP, reception staff members, practice manager and spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

# Are services safe?

## Our findings

**Safe track record and learning**

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

- Reception staff were unable to demonstrate that they understood what would denote a significant event and were unaware of any procedure to report events. The practice manager told us that the practice did not have a significant events policy or any formal reporting procedure. We were told that events would be discussed at a practice meeting but the practice manager was unaware of any events in the past two years and the practice did not document any minutes of meetings. However the GP showed us two completed significant event forms for the past two years, these reports were not detailed and had limited actions and learning outcomes, there was also no evidence that learning from these events were shared with other staff members. The incident recording form did not support the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice was unable to demonstrate that when things went wrong with care and treatment, patients were consistently informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

There were no safety records or incident reports and the practice did not have a system for responding to patient safety alerts, we were told that the practice had regular meetings where these would be discussed but the practice did not document agendas or minutes of any meetings and staff were unable to recall any events that had been discussed. Therefore we were unable to see that lessons were shared and action had taken place to improve safety in the practice. For example we saw an event noted by the GP about a GP giving a patient the wrong vaccination; the form did not include the date of the incident or the name of the patient affected. The action taken was to administer vaccines at the beginning of consultation and concentrate on the task at hand, lessons to be learnt included on the form was to pay attention to detail. There was no evidence that lessons learned or shared, or that action was taken to improve safety in the practice. There were no minutes of meetings where this was discussed.

**Overview of safety systems and processes**

The practice had no defined and embedded systems and the processes and practices in place were not sufficient to keep patients safe and safeguarded from abuse.

- Although there was a list of child safeguarding contacts in the staff reception area, reception staff members were unaware of this and there was no contact list for vulnerable adults. There were no safeguarding policies and the GP was the safeguarding lead, however reception staff were unaware of this and thought it was the practice manager. The staff were also unable to demonstrate they understood their responsibilities and along with the practice manager had not received safeguarding training. The GP told us that he always provided reports where necessary for other agencies.
- The GP and nurse had completed child safeguarding training level three. The practice did not have a register of at risk children or vulnerable adults and there were no multidisciplinary meetings where these potential patients could be discussed.
- A notice in the waiting room and consulting rooms advised patients that chaperones were available if required. The GP informed us that only the locum nurse who worked two sessions a week acted as a chaperone and patients would be asked to re-book at times when she was available if they required a chaperone when she was not at the practice. However both reception staff members told us that they acted as chaperones for locum GP's, they were not trained for the role and had not received a Disclosure and Barring Service (DBS) check or a risk assessment mitigating any risks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice manager was the infection control lead but he did not liaise with the local infection prevention teams to keep up to date with best

practice. There was no infection control protocol in place and staff had not received training. There were no infection control audits which meant that potential risks were not identified and improvements made.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Informal processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The locum practice nurse was administering vaccines without appropriate signed Patient Group Directions. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- There was no cold chain policy and there were two fridges which contained vaccines where the temperature had not been monitored since October 2015, we were told that if the fridge temperature went out of range it would beep to inform staff members, however reception staff said they would not know what to do if the fridge beeped. We also found vaccines in the fridge stored in their cardboard box delivery packaging, which was against storage rules as the packaging could affect the vaccine temperatures. We informed NHS England of this.
- We reviewed three personnel files and found appropriate recruitment checks had not been undertaken prior to employment. For example, references, qualifications and the appropriate checks through the Disclosure and Barring Service. We also found that the practice did not maintain the appropriate information such as registration with the appropriate professional body for nurses.

**Monitoring risks to patients**

Risks to patients were not assessed and well managed.

- There was an absence of procedures in place for monitoring and managing risks to patient and staff safety. There was no health and safety policy and the practice was unaware of who their local health and safety representatives were. The practice did not have a fire risk assessment, fire alarm testing and regular fire drills were not carried out and the fire extinguishers were last tested in 2009. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly, however this was one year overdue but we saw that this had been booked before the end of the inspection. The practice had no other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice was actively trying to recruit reception staff members and also had plans to recruit a female sessional GP.

**Arrangements to deal with emergencies and major incidents**

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Only the GP had received annual basic life support training. There were emergency medicines available in the treatment room.
- The practice used disposable clinical equipment, we found out of date syringes, needles, swabs and bandages in the treatment room.
- The practice had a defibrillator available on the premises, when we checked to see whether the defibrillator was in working order we found that the battery was low and needed replacing as the practice had no procedures in place for the systematic checking of equipment to ensure they were in good working

order. The practice did not have oxygen; however this was ordered and delivered before the second day of inspection and adult and children delivery systems were available. A first aid kit was available.

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely, however there was no system in place to ensure that these were monitored. We saw that all emergency medicines were received by the practice the day before inspection.
- The practice did not have a business continuity plan in place for major incidents such as power failure or building damage. The practice did not have arrangements for a buddy practice which could be used in the event of limited access to the practice premises.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GP assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, this however could not be demonstrated for the locum nurse.

- There was only one GP in the practice; he was in charge of keeping himself up to date. The practice used a regular locum nurse, there were no systems to ensure that she remained up to date, the practice did not have sight of and were unaware of whether the nurse attended clinical updates for procedures such as cervical cytology and childhood immunisations. The GP had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- There was no system for monitoring that these guidelines were followed, for example risk assessments, audits and random sample checks of patient records.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92% of the total number of points available, with an overall exception reporting rate of 9%. The practice had high levels of exception reporting in some areas (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

- 62% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented in the record in the preceding 12 months which was lower than the CCG average of 99%. There was17% exception reporting compared to the CCG average of 7% and the national average of 13%. The practice did not have an explanation for this and were not aware that they were an outlier.

This practice scored below CCG and national averages in some QOF clinical targets. Data from QOF showed:

- Performance for diabetes related indicators was below the national average.For example, the percentage of patients on the diabetes register with a record of a foot examination and risk classification within the preceding 12 months was 79% compared with the national average of 88%.
- Performance for mental health related indicators was lower than the CCG and the national average. For example, the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 62% compared with the CCG average of 85% and the national average of 84%. The exception reporting rate was 11%, which was higher than the CCG and national average of 7%.

  There was little evidence of quality improvement including clinical audit.
- We were told there had been two clinical audits completed in the last two years, however when asked we were only provided with evidence of one and this was a completed audit but there was no evidence of how action led to improvement.
- Findings were not effectively used by the practice to improve services. For example, due to information suggesting that the medicine amiodarone (used in cardiology patients) was being phased out because of potential side effects and lack of monitoring, the practice carried out an audit which found that three patients were being prescribed this medicine. None of the patients had recent ECG's and all three had relevant six monthly blood tests instead of three monthly as suggested by guidance. The re-audit found two patients being prescribed this medicine, one was under the care of a cardiologist where they received the required tests and the other had been referred to a cardiologist with the intention of stopping the medicine. The audit did not include any learning or any actions to be taken in the future.
- The practice participated in local audits, local benchmarking was provided by the CCG and there was no peer review.

Inadequate

# Are services effective?

## (for example, treatment is effective)

The practice was unable to demonstrate how information about patients' outcomes was used to make improvements to patient care.

**Effective staffing**

There was no system in place to enable and monitor staff training; we found no evidence of any non-clinical staff training in the past three years. There was also no process for ensuring and monitoring that the nurse kept up to date with the required training updates required for effective care and treatment. We did however see that the GP remained up to date with training according to the requirements of his appraisal.

- The practice did not have an induction programme for all newly appointed staff; we were told that inductions were an informal process that mainly involved shadowing appropriate staff members.
- The practice could not demonstrate how they ensured role-specific training and updating for nurses, however the GP was the responsible person for reviewing patients with long-term conditions and his training was up to date.
- The practice could not demonstrate how staff administering vaccines and taking samples for the cervical screening programme remained up to date with specific training including an assessment of competence. The GP who administered vaccines could not demonstrate how he stayed up to date with changes to the immunisation programmes, for example by access to on line resources, attendance at immunisation updates and discussion at practice meetings. We looked in the nurses file and saw no evidence of update training and the practice manager and GP were not assured that these had taken place.
- The practice did not have a means of effectively identifying the learning needs of staff, we were told that this happens through general discussions, meetings and a system of appraisal, however we found no appraisals on record, no evidence of meetings and no reviews of practice development needs. Staff did not have access to appropriate training to meet their learning needs and to cover the scope of their work including ongoing support, one-to-one meetings, coaching and mentoring.
- Non-clinical staff members did not receive training, including safeguarding, basic life support and information governance. No members of the practice had received fire safety training and there were no allocated fire marshals.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way when referring patients to other services.

Staff could not demonstrate how they worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice was not a part of any multidisciplinary meetings with other health care professionals where care plans could routinely be reviewed and updated for patients with complex needs.

**Consent to care and treatment**

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was recorded in the patient record but was not monitored.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support. For example:

Inadequate

# Are services effective?

## (for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A dietician was available from a local support group and smoking cessation advice was available on the premises.

The practice's uptake for the cervical screening programme was 75%, which was comparable to the CCG average of 78% and the national average of 82%. There was no policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice could not demonstrate how they encouraged uptake of the screening programme. There were no failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme but the practice followed up women who were referred as a result of abnormal results. However the practice did not monitor inadequate cervical cytology rates and were unaware of whether the locum nurse had attended cervical cytology training updates.

There were no system for the practice to improve uptake or encourage its patients to attend national screening programmes for bowel and breast cancer screening. However the practice was not an outlier in this area and was comparable to the CCG and national averages. For example 64% of female patients aged 50 to 70 were screened for breast cancer in last 36 months, which was similar to the CCG average of 68% and the national average of 72%. Fifty percent of patients aged 60 to 69 were screened for bowel cancer in last 30 months, which was similar to the CCG average of 49% and the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and slightly lower than the national averages. For example, childhood immunisation rates for the vaccinations given to five year olds ranged from 65% to 92% compared to the CCG averages of 66% to 89% and the national averages of 88% to 94%.

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

Requires improvement

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

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

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

All of the 31 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two patients, they also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to the CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients said the GP was good at listening to them compared to the clinical commissioning group average of 88% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 75% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

**Care planning and involvement in decisions about care and treatment**

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 75% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 85%.

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

- Staff told us that translation services were not available for patients who did not have English as a first language. Staff were multilingual and would act as an interpreter, if they did not speak the language of the patient, then patients were required to bring a family member to interpret for them. There were no notices in the reception areas informing patients of this. There was no consideration by the practice of patients who did not

have English as a first language who presented with a condition that would not be appropriate for a family member or a friend to interpret or for confidentiality issues in terms of giving results.

- There were posters displayed in the reception waiting area advising of services available.

**Patient and carer support to cope emotionally with care and treatment**

There were limited patient information leaflets available in the patient waiting area which told patients how to access support groups and organisations. The practice did not have a website where this information could also be advertised.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 14 patients as carers (less than 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them, they were also offered an annual influenza vaccine.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice could not demonstrate how they reviewed the needs of its local population, however they engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. This included securing funding for the refurbishment of the practice, which was due to commence at the end of January 2017.

- The practice offered extended opening hours on a Monday morning between 7:30am and 8am for working patients who could not attend during normal opening hours.
- There were two sessions of telephone consultations a day.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS, vaccinations only available privately were referred to other clinics.
- There were disabled facilities and a hearing loop.

**Access to the service**

The practice was open Monday to Friday between 8am and 6:30pm except Thursdays when the practice closed at 1pm to complete administration tasks. The practice had a morning extended hours appointments on a Monday, phone lines were answered from 8:30am and appointment times were as follows:

- Monday 7:30am to 8am, 9am to 11am (face to face), 11am to 1pm (telephone consultations), 3pm to 5pm (face to face) and 5pm to 6pm (telephone consultations).
- Tuesday, Wednesday and Friday 9am to 11am (face to face), 11am to 1pm (telephone consultations), 3pm to 5pm (face to face) and 5pm to 6pm (telephone consultations).
- Thursday 9am to 11am (face to face), 11am to 1pm (telephone consultations).

In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

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

- 71% of patients were satisfied with the practice's opening hours compared to the national average of 76%.
- 87% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

GP's contacted the patient by phone to assess the urgency of need for a home visit. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

**Listening and learning from concerns and complaints**

The system for handling complaints and concerns was informal and not effective.

- The practice had no complaints policy or procedures or complaints form that patients could complete and the practice were unaware of their contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- There was insufficient information available to help patients understand how to make a complaint, there was information in the practice leaflet and comments,

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

suggestions and complaints poster in the patient waiting area, however these did not advise patients on how they could take their complaint further if they were not happy with the practice's response.

There was no process for the practice to receive or learn from complaints and verbal complaints were not documented. We were told that there was one complaint received in the last 12 months, prior to this there had been no complaints recorded since 2013. We looked at the complaint which related to a patient not being happy with the medicine they were prescribed. We found that the patient received an explanation and apology in a timely manner, however documentation of the event was insufficient and learning from the event was limited "To stick to guidelines or request 24 hour ABP".

# 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 lack of systems, policies and protocols in place in the practice, did not support the GPs vision to deliver quality care.

- The practice did not have a mission statement and staff were unable to demonstrate they understood the practice vision.
- There were no strategies or supporting business plans reflecting the vision and values of the practice.

**Governance arrangements**

The practice had an overarching governance framework which did not support the delivery of the vision for good quality care. For example:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities but not always aware of the responsibilities and areas that other staff members led on, for example, there was confusion amongst reception staff members with who was the safeguarding and infection control leads.
- There were no policies available in the practice to govern activity.
- A comprehensive understanding of the performance of the practice was not maintained.
- There was no process for a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- There were no arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Non-clinical staff had not had training relevant to their role.

**Leadership and culture**

On the day of inspection the GP in the practice did not demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care, however, he told us they prioritised safe, high quality and compassionate care. Staff told us the GP was approachable and always took the time to listen to all members of staff.

The GP was aware of but had no systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included no support training for all staff on communicating with patients about notifiable safety incidents. The GP told us that he encouraged a culture of openness and honesty. The practice had ineffective systems in place that did not ensure that when things went wrong with care and treatment:

- The practice did not keep written records of verbal interactions as well as written correspondence and there was no process to ensure that interactions were captured.
- There was insufficient documentation of events to establish whether patients were consistently provided with an apology or reasonable support.

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

- Staff told us the practice held team meetings, these were not documented and when asked, staff members could not inform us of what was discussed at the last meeting.
- Staff told us there was an open culture within the practice and they would feel confident in raising any issues.
- Staff said they felt respected, valued and supported. The practice could not demonstrate how all staff were involved in discussions about how to run and develop the practice, and we saw no evidence that the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice could not demonstrate how they effectively encouraged feedback from patients, the public and staff. It did not proactively engage patients in the delivery of the service.

- The practice could not demonstrate how they gathered feedback from patients, there had been no patient survey or analysis of complaints and the practice did not

# Are services well-led?

Inadequate

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

have a patient participation group (PPG). There was a poster in the patient waiting area informing patients that they could leave a complaint or comment and the practice took part in the friends and family test, however the practice were unable to provide the results of this and they had not submitted results to NHS England in over four months.

- The practice could not demonstrate how they gathered feedback from staff members, staff told us they would not hesitate to give feedback, but there were no examples of when they had done this or when they had felt engaged and involved in improving how the practice was run.

**Continuous improvement**

There was no evidence of continuous learning and improvement at all levels within the practice. The practice team could not demonstrate that they were forward thinking and part of local pilot schemes to improve outcomes for patients in the area, for example the risk avoidance scheme which aimed to keep older patients out of hospital and well at home.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>How the regulation was not being met:<br>The provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users.<br>The practice failed to mitigate any risks associated with fire safety, a fire risk assessment had not been carried out, there was no testing of fire alarms or fire drills and no staff members had completed any fire training.<br>There were no processes in place to ensure that emergency equipment and medicines, and equipment such as syringes were in date and in good working order.<br>The nurse was providing immunisations without the use of PGDs.<br>The provider had not ensured that there were infection control and infection measure in place including legionella testing.<br>The provider failed to ensure that the necessary pre-employment checks had been completed on staff members.<br>The provider failed to risk assess staff needing a DBS check to carry out chaperoning duties.<br>The provider failed to have systems in place to ensure significant events were recognised and dealt with effectively<br>There were no processes to ensure that the cold chain was maintained including no daily checking of fridge temperatures.<br>This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>How the regulation was not being met:<br>Recruitment procedures were not established and operated effectively to ensure that persons employed are of good character.<br>There were no processes in place to ensure that nurses remained registered and fit for their role.<br>This was in breach of regulation 19(1)(3)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>How the regulation was not being met:<br>The provider did not have systems or processes to ensure that risks were assessed, monitored, improved or mitigated.<br>The provider had no policies, protocols or procedures to govern activity.<br>Non clinical staff had not completed any training, the provider did not have arrangements to monitor role specific staff training.<br>Processes for receiving, recording acting on and sharing complaints were not effective.<br>The provider failed to have systems in place to ensure the reporting and recording of significant events giving people affected information about actions or outcomes. There was no process to escalate events to appropriate bodies if necessary.<br>The provider failed to have a business continuity plan in place and had not identified a buddy practice.<br>This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>How the regulation was not being met:<br>The provider did not have systems in place to ensure that nursing staff remained registered with the appropriate body and continued to meet the professional standards which are a condition of their ability to practise and a requirement for their role.<br>There were no systems in place to enable staff appraisals or access to training to non-clinical staff to carry out their role effectively. |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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