Kirkby Community Primary Care 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?	**Requires improvement**
Are services responsive to people's needs?	**Inadequate**
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 Kirkby Community Primary Care Centre on 13 May 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice to be inadequate for providing safe, effective, responsive and well-led services and requiring improvement for caring services. The concerns which led to these ratings apply to everyone using the practice including the population groups of 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. All of the population groups have been rated as inadequate.

Our key findings were as follows:

- Data showed outcomes for some patients were significantly below average for the locality. Although some audits had been carried out, they had not been completed and we saw no evidence that audits were driving improvement in performance in respect of patient outcomes.
- Patients said they were treated with compassion, dignity and respect, although some patients expressed concern about the lack of continuity in their care.
- Patients had mixed views about appointments. Most told us that non-urgent appointments were usually available. However, some patients told us it could be difficult to get an urgent appointment.
- The number of patients visiting a local 24 hour walk in centre was 95% higher than the local average. We also saw that the number of patients attending accident and emergency department was 24% higher than the local average. The practice was aware of this, although had not investigated the reasons.
- The practice had not been handling complaints in line with national guidance and there was no evidence that learning from complaints was being shared with practice staff to improve the service being delivered.

There were areas of practice where the provider needs to make improvements.

Summary of findings

Importantly, the provider must:

- Ensure that the recording, investigation and dissemination of learning from significant events is robust.
- Ensure that assessment and care that is offered to patients is recorded and reflects recognised national guidance.
- Provide all staff at the practice with appraisals and the regular opportunity to explore individual training needs relevant to their role.
- Improve the handling, recording and dissemination of learning from complaints received to enable lessons to be learned and secure service improvements.
- Actively seek the views of patients and those acting on their behalf about how the care and treatment provided meets their needs and use this to assess and monitor the quality of the service.
- Ensure that all equipment used in the practice has been tested to ensure it is safe and fit for purpose.

In addition the provider should:

- Improve security for the issuing and tracking of blank prescription forms to reflect nationally accepted guidance as detailed in NHS Protect.
- Specify the levels of training required for locum GPs in the service level agreement with recruitment agencies.

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?

Inadequate

The practice is rated as inadequate for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not shared so any 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. For example, the handling of blank prescription forms did not meet national guidance.

Are services effective?

Inadequate

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

Data showed that care and treatment was not delivered in line with recognised standards and guidelines. We saw examples of when care did not meet nationally expected standards. The practice had not implemented individualised care plans for over 100 patients who were at high risk of admission to hospital as they had committed to do. The purpose of an individualised care plan is to regularly assess and modify the care and treatment of these patients, many of whom had complex needs

Patient outcomes were hard to identify as little or no reference was made to audits and there an absence of evidence to demonstrate that the practice was comparing its performance to others; either locally or nationally. There was minimal evidence of engagement with other providers of health and social care. For example, the practice had not held a practice led multi-disciplinary team meeting to discuss the care needs of patients approaching the end of their life since July 2014. There was limited recognition of the benefit of an appraisal process for staff.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made. We saw a number of examples when the care provided did not met the required national standards. For example, 25% of patients who had a new diagnosis of cancer had received a review of their condition with six months. This performance was significantly lower than the CCG average of 90% and national average of 92%.

Summary of findings

Data showed that patients rated the practice higher than others for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to. Information for patients about the services was available but not everybody would be able to understand or access it. Six of the ten patients we spoke with told us the continuity of their care concerned them.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. Feedback from patients indicated that access to a named GP and continuity of care was not always available. The number of patients visiting a local 24 hour walk in centre was 95% higher than the local average. We also saw that the number of patients attending accident and emergency department was 24% higher than the local average. The practice was aware of this, although had not investigated the reasons.

Patients could get information about how to complain in a format they could understand. However, there was limited evidence that complaints were being responded to in a timely and robust manner in line with the provider policy. We also saw that learning from complaints had not been shared with practice staff for a number of months.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It had a vision and a strategy all staff were aware of these and their responsibilities in relation to upholding them. There was a documented leadership structure however most staff felt they were not supported by the management team. Practice governance meetings had not been held for over six months, although they were plans in place to start these again. Poor performance in relation to the clinical review of patients with long-term conditions had not triggered an investigation of the reasons and the action needed to improve the situation had not either not been taken at all or had not been taken quickly enough to protect patients from risks to their health and wellbeing.

The practice had an active patient participation group (PPG), although a member of the PPG told us they faced barriers to improving services. All staff had received inductions; however staff had not received a recent appraisal nor had recent involvement in developing a personal development plan.

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 practice is rated as inadequate for the care of older people. We saw evidence that basic care and treatment requirements were not met. For example, the practice had not implemented care plans for patients at high risk of unplanned admission to hospital, many of which were older patients.

Patients over 75 did not have a named GP, as the practice did not have a permanent regular GP. A local GP had been recruited to act as a interim lead GP and was expected to take on the role.

The care of older people was not managed in a holistic way. For example, the practice had no patients on the practice register for patients who had fractured a bone because of osteoporosis (a condition which leads to fragile bones), this condition can affect patients of any age but is more common in older patients. We were concerned about the absence of diagnosed patients as data from the National Osteoporosis Society suggests that half of patients aged 75 years and over will have osteoporosis as measured on a bone density scan.

We spoke with a member of nursing staff from a local care home who told us that GPs from the practice had stopped doing weekly visits due to the shortage of clinical staff at the practice. Services for older people in care were therefore reactive, and there was a limited attempt to engage with this patient group to improve the service.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well-led services and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

We saw that measures to provide higher levels of support to help patients with long-term conditions had not been implemented. For example, the provider had not implemented comprehensive care plans for patients at higher risk of unplanned admission to hospital as it had been contracted to do. Patients told us that urgent appointments were not always available and that the lack continuity of care concerned them.

A audit into the treatment of patients with a long-term condition revealed 46% of patients with the condition may not have received the best treatment for their condition. There was no evidence to show that learning from the audit had been shared or that a repeat audit had been undertaken to ensure the situation had improved.

Summary of findings

The practice performance outcomes in relation to the review of patients with long-term conditions were in line with the national average.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. We saw that joint weekly working with the health visitor to discuss children subject to child protection had not been held for over six months. Staff told us that issues were discussed as required. The practice had recently appointed a interim lead GP to take responsibility for safeguarding children.

Data supplied by the clinical commissioning group (CCG) showed that the practice levels of childhood immunisations had reduced significantly during the last year and were significantly below local averages. For example, in April 2014 the practice rate for providing the measles mumps and rubella (MMR) vaccine to children aged two was 93.5%. In June 2014 the rate was 85.4% and December 2014 the rate was 78.6%. This was significantly lower than the CCG average of 95.5%. Appointments were available outside of school hours.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well-led services and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Appointments held outside of working hours had sometimes needed to be rescheduled due to a lack of availability of GPs available to cover appointments within these hours.

The practice offered services that helped patients in this group to access services, For example, online services, telephone appointments and health promotion screening.

The practice performance outcomes within conditions and investigations undertaken that were common in this patient group were in line with the national average.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

The practice kept registers of patients who circumstances may be vulnerable, including those with a learning disability. We requested information from the provider to establish that care provided to patients with a learning disability met nationally recognised standards. This information was not provided despite our requests.

Summary of findings

On site clinical leadership at the practice had been absent for a number of months. We saw that the absence of on site clinical leadership and lack of knowledge of patients whose circumstances may make them vulnerable could mean that their care needs were not fully met.

People experiencing poor mental health (including people with dementia)

Inadequate 

The provider is rated as inadequate for the care of patients experiencing poor mental health (including those with dementia).

Provider supplied data showed that outcomes in this group were significantly below the local and national averages. For example:

- The practice rate for annually reviewing patients who experienced poor mental health was 23%. The CCG average was 68% and national average 75%.
- The practice rate for annually reviewing patients with dementia was 15%. The CCG average was 78.8% and national average 77.9%.
- The rates of review within a nationally accepted timescale for patients who had experienced depression were 3%. This amounted to two patients out of a total of 70.

The results had not triggered a satisfactory response from the provider to investigate the reasons why performance levels were low and that the care provided was appropriate.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015. The survey included responses collected during January to March 2014 and July to September 2014. There were 356 survey forms sent out of which 109 responses were received. It should be noted that this survey was undertaken during a time period when the practice had permanent salaried GPs and nursing staff based at the practice. The survey results about how patients felt care was provided were broadly in line with local and national averages. For example, 71% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and national average of 82%. In the survey patients' views on appointments were again broadly in line with local and national averages. For example, 81% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 74%.

We spoke with 10 patients during our inspection. Six of the patients we spoke with told us that they were concerned at the lack of continuity in their care with. All six of the patients used the practice regularly due to their medical conditions and told us that the service had deteriorated in recent months. All of the patients we spoke with said that they were treated with dignity and respect and told us that the practice appeared visibly clean. Four of the patients we spoke with said it could be difficult to get an on the day urgent appointment. All of the patients we spoke with told us that they could book an advance appointment without difficulty, although six commented that they could not normally see the same GP.

We collected 11 Care Quality Commission (CQC) cards from a comment box left in the practice in the practice waiting room for two weeks before our inspection. All of the cards contained positive comments about the practice and staff. We saw that four comment cards expressed concern at the lack of continuity of care from GPs. Five cards contained comments about difficulty in obtaining an appointment that met the needs of the patient.

We met with a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. They told us that it had sometimes been difficult to get the practice to adopt changes and work in partnership with them. For example, it took nearly one year to arrange a place for the patient suggestion box to be sited in the practice waiting room.

The practice had not completed a patient satisfaction survey of its own. They had recently introduced the friends and family test. The results were not available at the time of our inspection.

We reviewed comments about the practice on the NHS Choices website. NHS Choices is a website that contains information about health topics and the services that provide healthcare. We saw that 38 reviews had been posted on the page for the practice. Ten reviews had been posted within the previous six months. Two of the ten reviews were positive. Eight reviews expressed dissatisfaction with access to appointments or problems in contacting the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure that the recording, investigation and dissemination of learning from significant events is robust.
- Ensure that assessment and care that is offered to patients is recorded and reflects recognised national guidance.
- Provide all staff at the practice with appraisals and the regular opportunity to explore individual training needs relevant to their role.
- Improve the handling, recording and dissemination of learning from complaints received to enable lessons to be learned and secure service improvements.

Summary of findings

- Actively seek the views of patients and those acting on their behalf about how the care and treatment provided meets their needs and use this to assess and monitor the quality of the service.
- Ensure that all equipment used in the practice has been tested to ensure it is safe and fit for purpose.

Action the service SHOULD take to improve

- Improve security for the issue and tracking of blank prescription forms to reflect nationally accepted guidelines as detailed in NHS Protect.
- Specify the levels of training required for locum GPs in the service level agreement with recruitment agencies.

Kirkby Community Primary Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team also included a GP and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Kirkby Community Primary Care Centre

Kirkby Community Primary Care Centre is situated in the premises of the Ashfield Health Village. The practice is all on a single level and occupies a converted former ward area. There are 10 consulting and treatment rooms. There are approximately 5,700 patients of all ages registered at the practice.

The practice first opened in 2008 as a new facility for patients in the area. This followed a government led review into the NHS. The report Next Stage Review (2008) recommended the introduction of 100 new GP practices, of which this practice was one.

The practice is operated by Central Nottinghamshire Clinical Services (CNCS) under an Alternative Medical Provider Services contract with NHS England. The practice is also contracted to provide a number of enhanced services, which aim to provide patients with greater access to care and treatment on site. CNCS have held the contract since 2008 and hold responsibility to provide services until August 2016.

The staffing establishment at the practice has changed significantly in recent months. From November 2014, regular clinical staff levels have reduced from three salaried GPs, one advanced nurse practitioner and one practice nurse to no fulltime regular clinical or qualified nursing staff employed at the practice. At the time of our inspection and for some months before it, the GPs and majority of nursing staff at the practice are provided as locums under arrangement with recruitment agencies. CNCS seconded an experienced nurse practitioner to provide nursing care at the practice in March 2015. The practice also employs a female nursing assistant.

The practice administrative team consist of eight members of staff. The practice manager had been recently appointed (April 2015) to the role, following the previous practice manager resigning in December 2014. In the interim the provider told us that support had been provided from other managers in the CNCS network.

The practice is open between 8am and 6:30pm Monday to Friday. Extended hours appointments are offered until 8pm on Monday and Friday.

The practice does not provide out-of-hours services to the patients registered there. These services are provided by PC24, which are also part of CNCS.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions and in response to information we received. 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 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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 May 2015. During our visit we spoke with a range of staff including the chief executive and medical director of the practice provider organisation; two GPs (one seconded as a interim lead GP and one locum) a seconded practice nurse, a healthcare assistant the practice manager and three members of reception and clerical staff. A member of the patient participation group (PPG) spoke with us to share their experience of the relationship between the practice and PPG. We also spoke with ten patients who used the service. We observed how people were cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

We also spoke with a senior nurse from a local health partnership team that provided support to patients with higher care needs and a nurse from a local care home that provide nursing and residential care to a number of patients that are registered at the practice after the inspection. We did this to confirm that the care and services met the needs of patients, mainly of which were older people or people whose circumstances make them vulnerable.

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 whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

Inadequate

Are services safe?

Our findings

Safe track record

The practice had a comprehensive policy in place for reporting and managing serious incidents. All of the staff we spoke with were aware of their responsibilities to raise a concern and knew how to report incidents and near misses. For example, a member of reception staff had completed a serious incident form to report that a member of staff had left sensitive paperwork in a non-secure place. Staff told us that they had previously completed and submitted incident forms to the practice manager. They told us that incidents had been previously discussed at monthly practice meetings where learning was shared; we reviewed copies of the minutes of meetings which confirmed discussion of incidents had taken place. The staff we spoke with told us that the practice meetings had not taken place since November 2014. They told us that incidents recorded after December 2014 had been submitted to the provider's headquarters and that they had not received feedback on incidents after this date.

We asked the provider to submit a summary of significant events at the practice from 2014-2015 before our inspection date. We did this to review the incidents to look for common themes and to help decide if learning from events was evident. These were not supplied to us in spite of this being requested before, at the time and after our inspection. The current medical director had not been employed within the provider organisation in 2014 and told us that they were unable to account for the process of incident handling at that time. The policy for the reporting and management of serious incidents had been in place within the provider organisation since January 2014.

We were unable to review safety records and incident reports as members of the practice team were unable to locate them. We asked the practice's provider organisation to send us records from 2014. We have not received these records in spite of our request. In the absence of evidence to the contrary we were not assured that the provider had managed incidents that may affect patients' safety consistently and they could not show evidence of safe track record over the long term.

Learning and improvement from safety incidents

Staff we spoke with told us that the practice clinical staff previously met on a monthly basis and there had been monthly practice meetings for all staff. We saw evidence of this in the minutes of meetings held from March 2014 to November 2014. We saw that significant events had been a standing item on the agenda for both meetings and we saw that discussion and sharing of learning points had taken place. The records that detailed the significant events were not available as practice staff and team members from the provider organisation could not locate them within the practice. The incident reports had been removed from the practice and were handled at the headquarters of the provider organisation.

The practice team had not held any form of internal meeting to discuss safety incidents since November 2014. The staff we spoke with told us this was due to the lack of on-site clinical leadership. The medical director told us that they had recently appointed an experienced local GP to provide on-site clinical leadership for three days a week. We spoke with this GP who told us they planned to reintroduce the clinical meetings to improve learning from safety incidents within the practice team.

We reviewed a summary of serious incidents from January 2015 to March 2015 (also known as Q4); these records were submitted to us after the date of the inspection. The records showed that there had been four recorded serious incidents that all related to issues surrounding the handling of information during the three months. We were unable to confirm that these were an accurate reflection of the incidents as we had not been able to review the detailed documentation of the investigations and outcomes.

We also reviewed a summary of patients' complaints that were submitted in the Q4 period. We saw examples of complaints that would be considered to be significant events when compared with the National Patient Safety Agency (NPSA) produced guidance on significant event audit in primary care (2008). Significant events can be defined as an individual episode where there has been a positive or negative effect on the care for a patient. For example, we saw a summary of a complaint about a delay for a patient with complex care needs who needed more effective pain relief medicines. According to the 2008 NPSA guidance on significant event audit in primary care an incident of this nature would be considered to be a significant event. The complaint summary records we reviewed recorded a response of 'none identified' under a column that detailed if any lessons had been learnt.

Inadequate

Are services safe?

We spoke with the newly appointed interim lead GP who told us that they were not aware of the current process for dissemination of medicines or patient safety alerts. They told us they planned to implement an effective system for disseminating the information as a priority.

Reliable safety systems and processes including safeguarding

At the time of our inspection the GPs providing front line care at the practice were recruited and employed by a locum agency. The medical director told us that the practice held a service level agreement with two employment agencies. Both agencies subscribed to the principles of the NHS Employers produced guidance on the appointment and employment of NHS locum doctors (August 2013).

The service level agreement stated that the locum agency would ensure that the staff supplied would have appropriate experience and training for the role undertaken. Guidance published in March 2014 by the Royal College of Paediatrics and Child Health on safeguarding children and young people details the expected level of training for people who work with children and young people.

The guidance suggests that level three is the expected standard of safeguarding training to be undertaken by GPs. The two GPs we spoke with had both undertaken level three training and could demonstrate appropriate knowledge in the assessment, recording of and responding to issues or concerns when a child or young patient may be at increased risk of harm. The medical director told us that level three training was part of the appropriate training section of the service level agreement with the employment agencies. However, we did not see the level or description of the training specifically mentioned in the agreement documentation.

The GPs told us that they had received training in protecting adults who may be vulnerable. They were able to demonstrate appropriate knowledge and accurately describe the actions they would take if they had concerns.

We spoke with other staff at the practice who told us they had received training in both safeguarding children and vulnerable adults. They could describe the actions they would take if they felt a patient was at risk of abuse We reviewed training records which confirmed that staff had received training appropriate to their role. We saw that contact details for the escalation of safeguarding concerns were known and accessible to all staff.

The practice had a policy on safeguarding children and vulnerable adults that was accessible to staff on practice computers. The staff we spoke with knew of the existence of the policies and where to access them if required.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Staff told us that the former lead GP had held weekly meetings with a health visitor to discuss any issues or concerns. The meetings had not been held since October 2014. The practice did not have a formal lead on safeguarding although the medical director told us that the interim lead GP was tasked to take on this role.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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). Three members of reception staff and the healthcare assistant would act as a chaperone when required. They had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

We reviewed the process for receiving, storing and issuing prescriptions at the practice. We saw that the handling of both blank computerised and individual prescription forms did not meet national guidelines. The NHS Business Authority guidance "NHS Protect" provides guidance to staff members in all roles and healthcare settings who handle or issue prescriptions. The practice was not following this guidance.

The practice did not keep records to track the issue of blank prescription pads within the practice. The records we reviewed did not accurately and clearly show the number

of blank prescription pads in stock. We also saw that there were no records of the person issuing or receiving blank prescription pads. The practice did not have a system in place to monitor that the amount of blank prescriptions pads ordered and the number received was consistent with the amount of prescriptions that had been used. The absence of robust systems generated a risk of prescriptions being misused and could cause harm by individuals obtaining medicines which were not prescribed for them.

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures. The policy described the action to take in the event of a potential failure. We saw records to confirm staff undertook daily checks of the medicines, and they were maintained within the required temperature range.

Practice staff had recently started to check and record the temperature of the room in which medicines and vaccines were stored as the room temperature had been high. The practice manager told us that they were monitoring the room temperature daily to ensure that the medicines that were not stored in a vaccine fridge were being stored within their recommend temperatures. They had taken action to request relocation of the vaccine fridge. This was scheduled to be completed shortly after the inspection.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control and had received updates specific to their role. We reviewed records of the most recent practice audit which had been performed in April 2015. As a result of this audit, the practice had ordered additional colour coded sharps disposal boxes for disposal of medicines that could have been harmful if placed in contact with skin.

The practice had a number of policies to promote cleanliness and control infection. These included infection control and specimen handling. There were procedure documents and flowcharts to support these policies to enable staff to plan and implement measures to control infection. For example, we saw that clinical waste was separated from domestic waste. Staff were able to describe items that would be classified as clinical waste and how to dispose of them in a correct manner. There was a policy and procedure in case a member of staff suffered a needle stick injury.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

There was a good supply of personal protective equipment in the form of disposable gloves, aprons, eye protection and covers in clinical areas for staff to use to minimise the risk of the spread of infection.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment had not always been tested for electrical safety or calibrated to help to ensure that the equipment gave accurate results.

We saw examples of clinical equipment such as weighing scales, a nebuliser (a machine to deliver medicine into a patient's lungs) and an ophthalmoscope (to examine the eye) had not been calibrated. The nebuliser and ophthalmoscope had also not been tested for electrical

safety. The practice manager told us that this equipment had possibly been missed off the regular testing schedule. They told us that they planned to do a full inventory to ensure that all equipment in the practice was tested regularly.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained comprehensive evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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).

At the time of our inspection the majority of GP and nursing cover at the practice was provided by locum staff. The practice had two service level agreements with employment agencies to provide clinical and nursing staff. Both of the employment agencies subscribed to the NHS Employers produced guidance on the appointment and employment of NHS locum doctors (August 2013).

We reviewed the service level agreement documentation. We saw that the role and responsibility of performing recruitment checks was documented and assigned. The records we saw did not give details of the specific levels of training required for the role of a GP. For example, the level of safeguarding training, Mental Capacity Act 2005 training or basic life support training. The medical director told us that this would be included under appropriate training and experience and the employment agencies were aware of the level of training required for GPs. The locum GP we spoke with told us that they had last done basic life support training in 2013. The Resuscitation Council (UK) suggests that clinical staff in primary care should undertake at least yearly updates.

The impact of the recent departure of the GPs and practice nurses had affected the provider's ability to ensure there was always enough staff on duty. A member of the provider organisation told us about the steps that they had taken to attempt to recruit clinical staff. This included national advertising, the use of candidate finders and the offer of salaries at an enhanced rate. They told us that it had been challenging to provide locum cover at all times and on occasion evening clinics had been postponed. When this had occurred extra clinic sessions were arranged to accommodate patients whose appointments had been changed.

The clinical commissioning group (CCG) had sent a letter in April 2015 to all neighbouring GP practices to ask for support in providing a established GP to act as a caretaker whilst the staffing issues at the practice were addressed. A local GP had been appointed in early May 2015 as a interim lead GP for three days a week to provide clinical leadership and to have oversight for reviewing results, communications from hospitals and safeguarding concerns. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Two of the practice administration staff told us that it had been challenging to ensure that all tasks were completed in a timely way. They both felt this was due to the absence of a long-term practice manager since January 2015. Staff had been performing additional duties which included booking locums which would normally be undertaken by a practice manager. They told us that they had prioritised work and that the provider had recently authorised them to cover administrative and reception duties on overtime when required.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see in the staff room.

The staff we spoke with were aware of the procedure in place at the practice if a patient, visitor or member of staff was taken unwell suddenly. Information on emergencies and health and safety was also detailed in the locum pack available in each clinical and treatment room.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received recent training in basic life support. Emergency equipment was

available at a secure central point. Equipment included oxygen, a nebuliser (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). We saw that the defibrillation pads showed an expiry date of March 2015, practice staff told us that they would replace the pads. There were a number of pulse oximeters available (to measure the level of oxygen in a patient's bloodstream). All the staff knew the location of this equipment.

Emergency medicines were stored within a secure central area of the practice. The practice had medicines available to treat a range of medical emergencies. These included medicines to treat anaphylaxis (allergic reaction) and hypoglycaemia (very low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with staff and reviewed a range of practice supplied and national data which showed the practice was not effective in meeting the needs of patients at the practice.

The GPs and practice nurse we spoke with showed an understanding of how to access and implement best practice guidelines from the National Institute for Health and Care Excellence (NICE) and how to apply them into their individual practice.

The practice had not held any clinical or team meetings since November 2014. Staff told us this was due to the limited availability of clinical staff as the lead GP had left employment in October 2014. We reviewed minutes of previous meetings held prior to November 2014. We saw that the practice had previously regularly discussed changes to guidance and treatments. The minutes also showed that practice performance in referrals to other care settings and performance outcomes had been monitored.

The practice had been commissioned to provide enhanced services to the 2% of patients at the highest risk of unplanned admission to hospital with additional help and support. We saw that these patients did not have individualised care plans in place which are part of the requirements of this enhanced service. The purpose of an individualised care plan is to regularly assess and modify the care and treatment of these patients, many of whom had complex needs.

Practice supplied data revealed that over 100 patients who would be categorised into this group did not have individualised care plans in place. We spoke with a nurse at a local care home where a number of patients who had complex health needs lived. They told us that the staff at the care home were not aware whether the practice had individualised care plans from the practice in place for their residents. It was also unclear if patients were followed up following discharge from hospital, as the patients were not directly identified and had not received the Avoiding Unplanned Admissions Enhanced Service. We spoke with the medical director from CNCS who said they were unaware the care plans were not in place and would investigate the reasons for this.

A GP told us that a member of the medicines optimisation team from the clinical commissioning group (CCG) attended the practice regularly. This was to provide advice and check that patients had received medicines that were appropriate and there were no unusual patterns of prescribing. We looked at national data from the National Health Service Business Authority (NHSBA) from 2013 /14 and saw that prescribing levels for antibiotic prescribing and hypnotic (sleeping tablets) medicines were in the expected range.

We looked at data from the quality and outcomes framework (QOF) for 2013/14. We saw that the practice had achieved 89.1% of the QOF points available; this was lower than the national average of 94.2%. 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 and for the implementation of preventative measures.

The clinical exception rate for patients at the practice was more than double the local and national averages. We saw that 15.2% of patients at the practice had been reported as exceptions to receiving assessment or treatment. The CCG average was 8.1% and national average 7.9%. An exception is recorded in QOF when a patient does not receive the nationally recommended treatment or intervention. There can be a number of reasons for this including not attending the appointment on three occasions or not being suitable to receive the treatment for medical reasons.

The care of older people was not managed in a holistic way. For example, the practice had no patients on the practice register for patients who had a suffered fractured bone linked with osteoporosis (a condition which leads to fragile bones), this condition can affect patients of any age but is more common in older patients. Data from the National Osteoporosis Society suggests that half of patients aged 75 years and over will have osteoporosis as measured on a bone density scan.

The practice supplied data showed that patients who experienced poor mental health did not always receive annual health checks. We saw that 52 patients were on the practice register as they experienced severe poor mental health. Twenty-three per cent of patients on the register had been reviewed in the previous year. This amounted to 40 patients in total. We spoke with the medical director about the low rates of review in this group of patients. They told us that they had received information from the

practice that performance in all areas was on target and they were surprised to learn of low review rates. We saw that some areas of review for patients with poor mental health were in line with local and national averages. For example, 87% of females on the register had received cervical screening in the last five years.

Seventy patients who had been recorded as having experienced depression had been included on the practice register for depression. We saw that two patients had been recorded as receiving an initial assessment and follow up appointment to check on their progress. The remaining 68 patients had not received a recorded assessment or follow up. It was unclear if this was due to poor coding of assessments or the assessment not taking place. The low performance rates had not triggered any internal checking to ensure safe and good quality care and treatment was being provided or to investigate the cause of this poor performance.

The practice had a total of 61 patients on their register for dementia. We saw that the QOF performance for patients who had a recorded diagnosis of dementia was significantly lower than the local and national average. For example, 15% of patients with dementia had received an annual review of their condition. The data we reviewed was live data, therefore could not be directly compared with published data. QOF performance for 2013/14 for the CCG was 78.8% and 77.9% for the national average. The 2013/14 data showed that previously the practice review rates had been in line with, although slightly lower than, the CCG and national averages with a total of 75.9% patients with dementia receiving an annual health assessment.

We asked the provider after the inspection for the number of patients on the practice register for having a learning disability and had received an annual health assessment. The provider did not supply this information despite our request.

We reviewed data from Public Health England from 2014 this showed that the rates for using nationally accepted referral standards for patients with suspected cancer were in line with expected levels.

Management, monitoring and improving outcomes for people

The practice had recently employed an experienced local GP to act in a interim lead GP role to provide clinical leadership and monitoring of performance. Practice staff told us that patients had not been invited to attend clinical condition reviews in previous months as the availability of GPs time had been targeted at providing urgent appointments for patients.

The practice showed us two audits that had been undertaken in the last year. An example was an audit in October 2014 to check that patients who experienced atrial fibrillation (irregular heart rhythm) had received the most appropriate medicines to limit the risk of them developing complications. The audit found that 46% may not have received the best medicine for their condition. Guidelines on providing the most appropriate medicines were distributed to all clinical staff. The audit was due to be repeated three months after the initial audit. The purpose of repeating the audit would be to establish if outcomes had improved. Practice staff were unable to find any record of the audit being repeated and none of the staff we spoke with were aware of the audit. The other audit undertaken in March 2014 was on the outcomes of patients who had received a diagnosis of cancer. Practice staff were unable to locate any records of a repeat of the audit.

We saw records of meetings that discussed the care needs of patients who were approaching the end of their life. The meetings had been held regularly until July 2014, there had not been a formal meeting held since then. Staff at the practice told us that the meetings had not taken place since as there had not been a clinical lead to organise them.

We spoke with a senior nurse from the Integrated Care Multi-Disciplinary Team (ICMDT) within a local health partnership. They told us that the practice had been involved with monthly meetings to discuss patients that had a high risk score in a computerised predictive modelling tool. The meetings had taken place in every month in 2015, except for May. The computerised software was designed to identify patients at, or with, increasing risk of an unplanned admission to hospital. The senior nurse told us that they were due to meet with the new practice manager to take the initiative forward and plan regular future meeting dates.

The practice performance in QOF was varied. We saw that in most areas patient outcomes were broadly lower than the local and national average. For example, practice supplied data showed that 68.7% of patients with diabetes had received a recent blood cholesterol level test. National QOF data from 2013/2014 showed that the CCG average

Inadequate

Are services effective?

(for example, treatment is effective)

was 73.1% and the England average 72.3%. We saw that there were other areas of QOF where the practice performance was significantly lower than local and England averages.

Effective staffing

Permanent staff at the practice included a healthcare assistant and administrative team members. We reviewed staff training records and saw that all staff were up to date with attending courses such as basic life support and fire safety. We spoke with two GPs, the interim lead GP and a locum GP. Both were up to date with their yearly continuing professional development requirements and had been revalidated. (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).

We saw that staff at the practice did not have a documented appraisal or individual personal development plans in place. Four of the staff we spoke with told us that they had not had a recent appraisal. They told us a varied length of time since their last appraisal which ranged from 18 months to three years previously.

The practice health care assistant had undertaken training to provide extended duties which included spirometry (lung function testing) and blood pressure monitoring. The practice nurse that had seconded to the practice from the provider organisation was awaiting update training to enable them to administer vaccines.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support people with complex 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. All of the practice staff had a role in processing and acting on any issues that arose from communication with other care providers. The interim lead GP had committed to working three days a week to provide on-site clinical leadership and to play an active role in reviewing test results and communications about patients. We saw that that the review of blood test results and communications was up to date.

The practice had met with the multidisciplinary team (MDT) from a local health partnership on a monthly basis to discuss patients who had experienced a change in care needs. The patients had been identified via a computerised risk tool. We saw that other meetings that had previously been held regularly had not taken place for some months. For example, the last meeting that discussed the needs of patients who were approaching the end of their life was in July 2014. We asked how the care needs of patients in this group would be discussed; practice staff told us that some patients would be highlighted with changing care needs by the monthly MDT meetings with the health partnership.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made all referrals possible last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice also provided the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

All of the staff we spoke with were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. None of the clinical staff we

Inadequate

Are services effective?

(for example, treatment is effective)

spoke with had received formal training in the Mental Capacity Act 2005, although they understood the key parts of the legislation and were able to describe how they implemented it in their practice.

We saw that patients with complex health needs were not always supported to make decisions about their care and treatment. The practice had not implemented individualised care plans for patients who were at risk of unplanned admission to hospital under the enhanced service it was commissioned to provide. The care plans provide patients with the ability to record decisions to ensure their wishes are followed in the event that their capacity to make or communicate decision changes.

Patients with conditions that may lead to mental capacity becoming diminished had not been reviewed regularly. This included patients with dementia and those who experienced poor mental health.

We asked clinical staff about their understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). The staff we spoke with were able to accurately describe Gillick competencies.

Health promotion and prevention

The practice offered a range of health promotion enhanced services at the practice in response to the CCG and Public Health England making these available. Examples were smoking cessation and weight management.

It was practice policy to offer a health check with a member of nursing staff to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We reviewed the latest practice supplied data from QOF which gave the live practice outcomes, to establish the practice performance for providing health promotion and prevention.

We saw that the practice cervical screening uptake rate was 90% which was higher than the CCG and England average of 77%. The practice nurse told us that she followed up patients who did not attend to highlight the importance of regular screening.

The practice supplied data from January 2013 to December 2014 showed that immunisation rates for children were lower than the local average. We saw that the practice performance for immunisation had deteriorated between the months of June 2014 to December 2014. For example, In April 2014 the practice rate for providing the measles mumps and rubella (MMR) vaccine to children aged two was 93.5%. In June 2014 the rate was 85.4% and December 2014 the rate was 78.6%. This was significantly lower than the CCG average of 95.5%. We spoke with the seconded practice nurse about this performance; they told us the low immunisation rates were a result of the lack of availability of a suitably trained practice nurse. They also said that they planned to improve the performance by providing the immunisations following update training.

NHS Health Checks were provided to eligible patients in the age range of 40 to 74 years. The CCG data we reviewed on the practice performance for providing NHS checks showed the practice had not performed the planned number of NHS checks. The practice had completed 50% of the expected number of NHS Health Checks from April 2014 to December 2014. This was lower than the CCG performance average for the same time period of 96%.

The practice employed a health worker who organised regular walks for patients to encourage exercise.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The survey included responses collected during January to March 2014 and July to September 2014. There were 356 survey forms sent out of which 109 responses were received. It should be noted that this survey was undertaken during a time period when the practice had permanent GPs and nursing staff based at the practice.

The evidence from the national patients survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated in line with others for patients who rated the practice as good or very good. The practice was also average for its satisfaction scores on consultations with GPs and nurses. For example:

- 83% said the GP was good at listening to them compared to the CCG average of 84% and national average of 88%.
- 84% said the GP gave them enough time compared to the CCG average of 84% and national average of 86%.
- 88% said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and national average of 93%.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 11 completed cards. All of the cards contained positive comments about the practice and staff. The reception staff received praise which described them as helpful and caring in all but one card. Five cards contained comments that expressed it was sometimes difficult to get an urgent appointment and four cards contained comments on the lack of continuity of GPs. We also spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The practice displayed a patient suggestions box that had been implemented following consultation with the PPG . PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. We saw that there were four responses in the suggestion box. All four comments were negative, three related to difficulty with appointments and one related to a patient felt a clinical member of staff had been rude. Practice staff were unsure when the box had last been emptied although they felt this would have been a number of months ago.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Modesty curtains and blankets were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located in another office and away from the reception desk which helped keep patient information private. Staff on reception wore headsets to help avoid people in the waiting room overhearing conversations on the telephone. A system operated to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 92% said they found the receptionists at the practice helpful compared to the CCG and national averages of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice below others in these areas. For example:

- 71% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and national average of 82%.
- 69% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 75%.

Six out of the 10 patients we spoke with expressed concern at the lack of continuity of the care they experienced due to

the high number of locum GPs used at the practice. The patients expressed that they used the practice regularly and felt they needed to repeat their medical history each time as the GP seeing them changed each time. Four patients we spoke with who did not use the practice regularly told us they had not noticed a change in the GP staffing.

We saw that groups of patients had not always received involvement in decisions about their care and treatment. For example, the practice supplied data showed:

- None of the patients who had complex medical needs that meant they were at risk of unplanned admission had a suggested care plan in place. This amounted to over 100 patients in total.
- 23% of patients who experienced poor mental health had a personal health plan in place.
- 15% of patients on the practice register for dementia had received a review of their condition in the previous year.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were less positive about the emotional support provided by the practice GPs and rated it slightly below average in this area. For example:

- 76% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 83%.

Satisfaction rates about the emotional support provided by practice nurses was more positive, for example:

- 76% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 71% and national average of 67%.

Notices in the practice waiting room and information on the website signposted patients to a number of support groups and organisations.

Families who experienced a bereavement were contacted where appropriate. A GP told us based on the individual circumstances a GP would call the families if this was suitable. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was not always responsive to patients' needs. The recent departure of the regular GPs had affected the ability of staff to meet the needs of all patients. The review of patients with some medical conditions which needed to be reviewed by a GP were significantly below the local and national averages.

We spoke with a member of nursing staff from a local care home. The care home had all of the residents who lived there registered at the practice. The nurse told us that until recently a GP had visited the care home on a weekly basis to review patients. They told us that the visits had been stopped due to the lack of availability of GPs made it difficult for the practice to arrange visits. They told us the practice GPs had always been responsive to requests to home visits and they could call a GP for advice or a home visit if required.

The healthcare assistant told us that the practice offered longer appointments for those who needed them. This included patients undertaking spirometry (lung function) tests and those attending reviews for long-term conditions, for example, diabetes.

Appointments were offered outside working and school hours which benefited patients who worked and younger patients.

The practice's provider organisation had been working very closely with the local clinical commissioning group (CCG) to find a solution to the shortage of regular GPs to staff the practice. As a result of discussions the CCG had contacted all local GPs and a interim lead GP had been appointed for three days a week. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We spoke with a member of the patient participation group (PPG) about the interaction between the practice and PPG. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. They told us that their experience of the relationship between the practice and PPG had been mixed. The PPG met on a monthly basis and a member of practice staff had attended each meeting. The PPG member told us that the practice had been slow to respond to ideas that had been suggested by the PPG. For example, it had taken over a year to put up a noticeboard to display information about the PPG and their role. They also told us that the group members had been told that they could not use the practice refreshment facilities when having a meeting. The decision had been rescinded after consideration. We reviewed minutes of the PPG meetings that showed the group were keen to be involved with improving services to patients, although did not feel that their efforts were valued.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of patients in the planning of its services. For example, staff told us about how they adapted the registration process to allow patients who were homeless and those from the traveller community to register at the practice. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

Facilities at the practice for the consultation and treatment of patients were all situated on the ground floor. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. There was a hearing assistance loop available for patients and visitors who used hearing aids.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed this training in the last 12 months.

Access to the service

The practice was open from 8am to 6:30pm on Monday to Friday. During these times the reception desk and telephone lines were always staffed. Appointment times varied during different times throughout the day and had reflected the availability of the locum GPs. Evening appointments were available from 6:30pm to 8pm on a Monday and Friday. Patients could book appointments in person, by telephone and by using an online system for those had registered to access appointments in this way. A member of reception staff told us that appointments were a mixture of book on the day (for urgent health concerns) and pre-bookable (for routine concerns). We saw that there were urgent appointments available on the day of our

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

inspection and also pre-bookable appointments within two working days. The practice operated a telephone triage system when appointments became limited. A GP would call the patient and discuss their care needs.

Information about appointments was available on the practice website and in the waiting room. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

We reviewed data from the GP national patient survey information published in January 2015. The survey included responses collected during January to March 2014 and July to September 2014. There were 356 survey forms sent out of which 109 responses were received. It should be noted that this survey was undertaken during a time period when the practice had permanent GPs based at the practice. The survey data we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 78% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 74%.
- 81% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 74%.
- 86% said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 66%.
- 87% said they could get through easily to the surgery by telephone compared to the CCG average of 65% and national average of 72%.

The 10 patients we spoke with had mixed views on the appointments system. Four patients told us it had been difficult to obtain an urgent appointment; six patients told us they had managed to book urgent appointments when required. All of the patients we spoke with told us they could book a routine appointment in the future easily. The patient views in the 11 comments cards we received were also mixed. The five comment cards that mentioned appointments expressed difficulty in obtaining appointments, four related to the lack of availability of urgent appointments.

Performance data from the CCG from March 2014 to February 2015 showed that the number of patients using alternative care settings was higher than the local average. For example, The number of patients who attended a local 24 hour walk in centre was 95% higher than the local average. We also saw that the number of patients attending the accident and emergency department was 24% higher than the local average. We received two comments from patients in our comment cards about attendance at the walk in centre. One patient said that they would attend the walk in centre as urgent appointments were not easily available. The other patient said that they had attended the walk in centre and were directed to see their GP, on telephoning the practice they had been unable to get an appointment within a week. The medical director told us that they were aware of the high attendance rates and planned to audit to determine the cause.

Listening and learning from concerns and complaints

The provider had an outstanding requirement notice to improve their systems of recording, investigating and responding to complaints following an inspection at another registered location. They sent us an action plan detailing the steps to be taken to improve the situation. The action plan stated that their handling of complaints would be more robust by May 2015.

We saw that the system in place for handling complaints and concerns had not been followed and record keeping of complaints in the practice was poor. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints within the provider organisation, although they were not available to speak with on the day of our inspection.

We saw that record keeping was not of an acceptable standard. For example, the provider could not supply any records or summaries of complaints made in 2014. We asked for this information before, during and after our inspection. We also saw examples of complaints that had not been responded to quickly. The records we were able to review showed that a complaint received in 2013 had not been responded to for over 15 months.

The provider supplied us with a summary of complaints that had been received during January to March 2015. We were unable to review any details of complaints from April 2014 to December 2014 as practice staff members were

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

unaware where the records were stored. A member of practice staff told us that there had been a number of complaints in 2014 that had not been acknowledged or responded to. We saw examples of complaints received that raised concern over the treatment patients had received. For example, a patient approaching the end of their life had not received the pain relieving medicine they needed in a timely way. We were not able to review the records of the complaint to ensure that the practice had taken appropriate action on this and other complaints.

A member of practice staff told us complaints had previously been discussed at monthly practice meetings where learning was shared. We reviewed minutes of practice meetings and clinical meetings where complaints had been discussed and learning shared. The practice meetings and clinical meetings had not taken place since November 2014. Practice staff told us that any complaints received after January 2015 had been handled directly by the practice's provider organisation.

We saw that information was available to help patients to understand the complaints procedure was available on the practice website and in the practice waiting room. None of the patients we spoke with had ever made a complaint, although felt they could do this without prejudice.

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 practice was part of the Central Nottinghamshire Clinical Services group. The vision of the practice, within CNCS was to be a caring organisation. Staff had been involved in developing the values of being committed, approachable, respectful and exceptional team members. We saw that the staff at the practice had displayed these values and this was reflected in the comments we received from patients and our conversations and observations with practice staff on the day of our inspection.

The staff members including the administrative, reception and healthcare assistant had experienced an uncertain unstable workplace which had seen every member of clinical and nursing staff leave within a six month time period. The staff told us the effect of the departure on the staff had placed them under high levels of pressure with increased workloads and a lack on site clinical and administrative leadership had been difficult. All of the staff we spoke with were able to tell us about the practice values and their role in relation to them.

We saw that the provider had a service improvement plan in place. The document set out the challenges the practice had faced including improving the Quality and Outcomes Framework (QOF) performance, re-introducing team meetings, audits and complaint handling. 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 and for the implementation of preventative measures. The document stated the date for these areas to be improved was March 2016. Managers had been identified to be responsible for specific tasks and areas.

The former lead GP had left the practice in November 2014, the former long standing practice manager left the practice in December 2014 and the practice nurse had left employment in February 2015. The chief executive of Central Nottinghamshire Clinical Services CNCS told us that the organisation had implemented a number of measures to mitigate the loss of the clinical staff. This included national advertising for a lead GP, the employment of high performance recruitment agencies to recruit a GP and the secondment of a practice nurse and other manager within the organisation. These steps had not been sufficient to provide the stability in the staff team necessary to ensure continuity of care.

In March 2015 the practice had been subject to comments in the local media, which detailed that the practice was due to close. The chief executive of CNCS told us the article was incorrect, and led to a response by CNCS which included a meeting with the patient participation group (PPG) and producing information for patients to inform them that the practice was not closing.

The five staff we spoke with that were permanently based at the practice did not feel that they had been supported using the values of the practice organisation. They all told us that they felt undervalued and that they had been under high levels of stress and they had not been supported by their managers.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at four of these policies and all four had been reviewed annually and were up to date.

The leadership at the practice had changed a number of times in the months before the date of our inspection. The former practice manager had left in December 2014, a new practice manager from a primary care background had been appointed for two weeks. Between January 2015 and May 2015 other managers had provided support. The practice had not had a lead clinician since October 2014. An experienced local GP had been recruited to provide stability and clinical leadership in the short term whilst the longer term needs of the practice were addressed.

We saw that governance in a number of areas had not been robust. The practice performance in QOF had not been monitored effectively by the provider in the absence of consistent management. A high number of patients including those with poor mental health, dementia, cancer and depression had not received regular reviews and the QOF performance in these areas was significantly below local and national averages. For example, 25% of patients with a new diagnosis of cancer had received a review within the six months of diagnosis. The CCG average was 76% and national average 79%.

Are services well-led?

Inadequate

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

Practice meetings to discuss complaints, significant events and risks had previously been held monthly. No meetings had been held since November 2014. The executive team of CNCS told us that they had introduced executive meetings with staff on a monthly basis, although the staff we spoke with could not recall any recent items of governance related issues that had been discussed.

There was no ongoing programme of clinical audit within the practice. We saw two clinical audits that had been undertaken in the previous year. Both audits had not been repeated to check for improvements and the records we reviewed did not show that audits were discussed. The service improvement plan contained details of planned future audits that included telephone consultations and patient comments.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. However the provider did not have effective oversight of actual or potential risks to patients, staff or others due to the absence of effective oversight and governance systems. The practice risk file was held in the administration office. The practice manager who was new in post told us that they planned to familiarise themselves with the contents of the risk folder and take over monitoring risks on a regular basis to identify any areas that needed addressing.

The practice was part of a wider organisation. Staff in the organisation held responsibility for human resource policies and procedures. We reviewed a number of policies, for example, the recruitment policy which was in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

Leadership, openness and transparency

All of the staff we spoke with who were permanently based at the practice told us that they felt they had not been supported by the provider organisation management team. They told us that the team within the practice had given each other support; although they felt decisive leadership had not been visible enough in recent months.

We saw that both clinical and practice meetings had been held on a monthly basis until November 2014. The meetings had stopped following the departure of the lead GP, the long standing practice manager left in December 2014.

A new practice manager had been recruited and a interim lead GP appointed to provide clinical leadership on site. The practice manager told us that they were impressed with the resilience and spirit within the practice staff members. We saw the staff had been working hard to maintain the service and they showed desire to get the practice back to the level it had previously operated at.

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

We spoke with a member of the PPG about the relationship between the group and the practice. The PPG member told us that there were approximately eight members and they met at the practice on a monthly basis. They told us that the relationship between both parties had not always been productive. They told us that the group felt that the practice had put barriers in place to prevent them playing an active role in shaping services. For example, the PPG had proposed implementing a suggestions box that could be used to gather feedback from patients to use to improve services. A member of the PPG had constructed a suitable box and they felt it had taken the practice a period of months to place the box in the waiting room. They also told us that the group felt that they were not given guidance on the steps that could be taken to drive improvement. For example, the undertaking of a patient survey.

The practice was unable to provide us with copies of the PPG meeting minutes. The PPG member sent us copies in the post after the inspection, however we did not receive them. The Care Quality Commission (CQC) inspector contacted the practice three times in the two weeks before the inspection to request that the PPG were present at the practice to speak with the inspection team. The PPG member told us that they were only aware of the inspection the day before it took place. They told us they were not aware that any other members were asked to attend.

We reviewed comments about the practice on the NHS Choices website. NHS Choices is a website that contains information about health topics and the services that provide healthcare. We saw that 38 reviews had been posted on the page for the practice. Ten reviews had been

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posted within the previous six months. Two of the ten reviews were positive. Eight reviews expressed dissatisfaction with access to appointments or problems in contacting the practice. None of these had been responded to.

The staff we spoke with told us that they did not feel that they were listened to. A member of the executive team told us that had introduced monthly meetings with staff and they did value their staff and recognised that they could have been better supported through the high levels of change that had been experienced.

Management lead through learning and improvement

The healthcare assistant was the only member of nursing or clinical staff that was permanently based at the practice. They told us that they had been supported to undertake further training and development to provide additional services to patients. This included the provision of vaccination training and spirometry (lung function) testing.

All of the reception and administrative staff told us that they attended protected learning time on a regular basis. The time was used to update themselves on changes or new practice.

All of the staff we spoke with had not been provided with a recent appraisal. They told us differing timescales for the last appraisal they received that ranged from 18 months to three years. We checked recruitment files; there were no documented appraisals in place for any member of staff. Personal development plans were also not documented, although the attendance and documentation of training course such as annual basic life support and safeguarding training was present.

The practice had formerly been a GP training practice to provide placements for qualified doctors undertaking training to become GPs. This arrangement had ended in 2014.

The medical director told us that significant reviews had taken place although these had not been discussed with staff at the practice as meetings had not been held.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment was not provided as the number of patients who received annual reviews to determine their care needs was significantly below the nationally recognised guidance suggested review rate levels. The provider had not provided the care plans for patients at higher risk of unplanned admission to hospital as it had undertaken and been commissioned to do. The provider had not ensured that persons providing care and treatment to service users have the skills and experience to do so safely as no appraisals into performance were documented no none had been completed within a period of at least 18 months. The provider had not ensured equipment used to provide care or treatment was safe for use as items of medical equipment had not been tested to assure electrical safety or calibrated to ensure its accuracy. 12(1)(a) (b) (2) (c) (e)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance was not operated as the provider did not operate an effective system for handling incidents and handling the risks relating to the health, safety and welfare of people who used the service as no records of such incidents were available to view. Staff were unable to recall recent incidents and confirmed that they were not formally discussed and learning was not shared. The system to receive and act on feedback in the form of complaints from service users was not operated

This section is primarily information for the provider

Enforcement actions

effectively. Records were not held or available to promote good governance, feedback was not responded to on all occasions, learning points were not identified and shared with staff to encourage improvement of the service.

17 (2) (b) (d) (ii) (e)