Shanti Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. (At the previous inspection on 2 December 2014 the practice was rated as Good)

The key questions are rated as:

- **Are services safe? – Inadequate**
- **Are services effective? – Inadequate**
- **Are services caring? – Requires Improvement**
- **Are services responsive? – Inadequate**
- **Are services well-led? - Inadequate**

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

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

We carried out an announced comprehensive inspection at Shanti Medical Centre on 8 November 2017. The practice was selected as part of our inspection programme in response to concerning information received.

At this inspection we found:

- The practice did not have clear systems to manage risk so that safety incidents were less likely to happen again. When something went wrong, people were not always told. Safety was not a sufficient priority and there was limited monitoring of safety issues with high levels of serious or significant incidents.
- The practice did not routinely review the effectiveness and appropriateness of the care it provided. Care and treatment was not always delivered according to evidence-based guidelines.
- Not all staff had the right qualifications, skills, knowledge and experience to do their job effectively and the learning needs of staff were not fully supported.
- Some people who used the services, and stakeholders, had raised concerns with CQC and with the practice about poor access and care and

Summary of findings

treatment. However all feedback from patients on the day was positive. We saw that staff talked to patients with compassion, kindness, dignity and respect.

- The needs of the local population were not fully identified or taken into account when planning services, for example in the case of cervical screening. Some people were not able to access services for assessment, diagnosis or treatment when they needed to and action to address this was not done in a timely or effective way.
- Leaders were not workinging together for the benefit of the service and patients. Leaders did not consistently have the knowledge, capacity or desire to deliver an effective service and were out of touch with what was happening on a day to day basis. There was a lack of clarity about who had the authority to make decisions and quality and safety were not top priority. There was no clear vision or guiding values.
- There was no innovation or service development and improvement was not a priority among staff and leaders.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients in line with current guidance
- Ensure systems are in place so patients are protected from abuse and improper treatment
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Send CQC a written report setting out what governance arrangements are in place and any plans to make improvements.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

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

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

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

Shanti Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser, a second CQC inspector and a member of the CQC medicines team.

Background to Shanti Medical Centre

Shanti Medical Centre is a purpose built location that delivers regulated services at 130 St Helens Road Bolton BL3 3PH. The practice provides primary medical services under a General Medical Services contract to approximately 6,700 people in the immediate and surrounding areas of Bolton. More than 30% of the population are under the age of 18 years and less than 20% are over the age of 50 years. A large percentage of patients (approximately 76%) are from black and minority ethnic groups and the practice is located in an area that is number two on the scale of deprivation. People living in more deprived areas tend to have greater need for health services.

The practice is open Monday to Friday from 8am until 7.15pm. However until recently the practice has not been opening on time at 8am and this has caused delay to patients accessing services. On-the-day appointments can be booked over the telephone and at reception and advance appointments can also be booked by telephone and on-line. There are two male and one female GPs providing 23 appointment sessions each week with six sessions on Mondays to meet demand. The practice also provides telephone appointments and triage appointments each day. When the practice is closed patients are directed to the Out of Hours Service.

Other services include chronic disease management, immunisation, vaccination, well person and new patient checks. There is a practice nurse and health care assistant and a number of reception staff to support the GPs.

Full details about the practice can be found on their website www.shantimedicalcentre.nhs.uk

Inadequate

Are services safe?

Our findings

We rated the practice, and all of the population groups, as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because:

- The practice did not have clear systems to manage risk so that safety incidents were less likely to happen. When something went wrong, people were not always told.
- Safety was not a sufficient priority. There was limited monitoring and very high levels of serious or significant incidents.

Safety systems and processes

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

- The practice presented a list in excess of 28 serious incidents that had occurred in the previous 12 months. Some of those incidents revealed serious failures in administrative process or clinical judgement and included one error with the potential for serious or even fatal reaction by two patients. In addition there was evidence from the Clinical Commissioning Group, NHS England and our own intelligence that other incidents had occurred but had not been consistently investigated or documented.
- Some informal learning had transpired as a result of incidents and some informal changes to working practice had been initiated, but discussion, learning and change was not routinely and methodically taking place. There was no regular assessment of safety and risk.
- There was a suite of safety policies available on a shared drive, but they were not regularly reviewed and communicated to staff. We found a number of out of date policies and not all staff were able to find up to date information when they were asked about it.
- Staff did not receive safety information for the practice as part of their induction and they did not receive refresher training.
- The systems to safeguard children and vulnerable adults from abuse were not satisfactory. Policies were not regularly reviewed and accessible to staff and the safeguarding policy was out of date. None of the reception staff had undertaken safeguarding training since joining the practice up to ten months previously. The nursing staff had not received update training since they had joined the practice and their last recorded certification was in 2014 from previous employment. One of the GPs was unable to demonstrate their understanding or certification of Safeguarding Level 3. Staff did not have clear protocols or advice on whom to go to for further guidance although they did state that they would speak to either one of the GPs if they had any concerns.
- Another GP did have an appropriate awareness of safeguarding and there was evidence that they and the health care assistant did work with other agencies to support patients and protect them from neglect and abuse when they were known to the practice. This GP had recently taken steps specifically to protect female patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice did not carry out appropriate checks including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks had not been undertaken where required. (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). Staff who acted as chaperones were not appropriately trained for the role and had not received a DBS check.
- The system to manage infection prevention and control was not satisfactory. There was no regular infection control audits, no infection control lead and neither clinical nor administration staff had undertaken infection control training.
- There was no system in place to regularly check that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The practice was unable to provide evidence of gas and electrical safety testing, although recent portable appliance testing and calibration of equipment was evident.
- The systems for safely managing healthcare waste were not effective and we saw sharps boxes that were overfilled.

Risks to patients

Inadequate

Are services safe?

There were no systems to assess, monitor and manage risks to patient safety.

- Arrangements for planning and monitoring the number and mix of staff were re-active rather than pro-active
- There was no induction system for permanent or temporary staff tailored to their role.
- Not all staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. However, the GPs were able to describe how they would identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff there was no assessment of any impact on safety.

Information to deliver safe care and treatment

Staff did not always have all the information they needed to deliver safe care and treatment to patients.

- We looked at two care records to check the process for two week waits and found that they had been written and managed in a way that kept patients safe.
- The two referral letters we looked at included all of the necessary information.
- Another of the care records we looked at identified a clinical incident where due process had not been followed after the event.
- The number of clinical records that we were able to review in detail was less than the number of clinical incidents we were aware of and we were not satisfied that all information was consistently documented or that appropriate action was always taken and documented when errors occurred.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment but one of the GPs was unable to demonstrate their knowledge of those systems or how they would be used, for example, if they had concerns about a patient in an out of hours' situation.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment did not minimise risks. Blank prescription forms were kept securely but not all prescription pads were kept at the practice. The practice had recently introduced a log to track prescriptions from delivery to use within the practice. However, this had not been extended to all the practice prescription pads, and there was inconsistency from staff in their responses about how prescriptions were managed.
- Patient Group Directions had been adopted by the Practice to allow nurses to administer medicines in line with legislation. The health care assistant was also trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. However, patient specific directions (PSDs) were not in place for the health care assistant to admininster, for example, vitamin B12 and the flu vaccinations at the time of the inspection. Speaking with the GPs they did not have a clear understanding of the requirements to issue PSDs. Immediately following the inspection we asked the practice to initiate PSDs and provide assurances that vaccinations would not be administered by the health care assistant until the necessary documentation was in place. We received the necessary assurances and saw evidence of appropriate PSDs that had been implemented.
- The practice had completed an audit of patients at risk of diabetes to support improvement in care for these patients. However, the practice was unable to provide summaries of other clinical and prescribing audits showing how these were used to drive improvement.
- Emergency medicines were stored appropriately but there was no system for the completion of regular checks to ensure these would be suitable for use, if needed. Additionally, there was no protocol for responding to medical emergencies. Prior to our visit the 'caretaker' practice manager had found the oxygen and defibrillator pads to be out-of-date. They told us that replacements were on order and a system of checks would be implemented.

Track record on safety

The practice did not have a recent good safety record and there were a number of serious repeated errors over the previous 12 months.

- Comprehensive risk assessments were not routinely undertaken in relation to safety issues.
- There was a significant number of serious incidents and complaints in the previous 12 months.

Lessons learned and improvements made

Inadequate

Are services safe?

The practice did not consistently learn and make improvements when things went wrong.

- There was an inconsistent system for recording and acting on significant events and incidents. Staff did not all understood their duty to raise concerns and report incidents and near misses or who to report them to.
- The systems for reviewing and investigating when things went wrong were not adequate. The practice did not share and identify themes in a constructive way and they did not always take action to improve safety in the practice. For example following an incident where a medicine was incorrectly added and issued to the wrong patient the repeat prescribing policy had been reviewed. However, the Healthcare Assistant (HCA) was still authorised to process acute prescription requests. The HCA had not received training in this process and there was no protocol for them to follow. We saw incomplete review of some other incidents and in one example, the doctor had "declined to comment". In a second example, an investigation into the end of life care of a patient did not consider all aspects of the concern.
- There was no formal system for receiving and acting on safety alerts. The clinical staff learned about external safety events on a re-active basis and did not share information through meetings for discussion and improvement.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as Inadequate for providing effective services overall and across all population groups.

The practice was rated as inadequate for providing effective services because:

- There was evidence that not all patient's care and treatment reflected current evidence-based guidance, standards and practice.
- There was very limited monitoring of people's outcomes of care and treatment including limited clinical audit and necessary action was not taken to improve outcomes.
- People received care from some staff who did not have all the skills, experience, support or line management they needed to deliver effective care.
- There was no focus on prevention and early identification of health needs and staff were reactive, rather than proactive in supporting people to live healthier lives.

Effective needs assessment, care and treatment

There was no consistent system to keep clinicians up to date with current evidence-based practice. We saw that not all clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. For example, one of the GPs updated themselves when they felt it was necessary and the other was unable to demonstrate how they would access up to date guidelines on their computer. When asked how staff followed updated pathways and protocols, one of the GPs was unable to answer.

- Patients' needs were not always fully assessed. This included their clinical needs and their mental and physical wellbeing. We saw two examples where patients had received vaccinations that they had not required.
- The average daily quantity of hypnotics prescribed was two items which was higher than the CCG and local average of one item.
- The number of antibacterial prescription items prescribed per specific therapeutic group/age-sex related prescribing unit was average.
- The number of antibiotic items that were Cephalosporins or Quinolones prescribed was 3% compared to the CCG average of 4% and the national average of 5%.
- We saw no evidence of discrimination when making care and treatment decisions.

Older people:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

In addition :

- There was a very low number of people over the age of 50 registered at the practice and there was no way to determine whether any older patients at the practice were vulnerable or had complex needs because there was no register.
- Staff were not trained to recognise the particular needs of older people with complex needs to include their physiological, mental and communication needs.

People with long-term conditions:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

In addition :

- Data for 2016/2017 from the Quality Outcome Framework showed that the interventions required for patients with long term conditions such as diabetes, chronic obstructive pulmonary disorder (CoPD), heart disease and asthma were all between 12% and 50% lower than the local and national averages.

Families, children and young people:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

However :

- The practice was above standard for providing required immunisations to children between the ages of 0-5 years.
- The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 86% which was better than the CCG and national averages of 82%.

Inadequate

Are services effective?

(for example, treatment is effective)

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

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

In addition :

- Until recently the practice had not been opening on time and this was preventing working people from accessing services they were entitled to in a timely way.

People whose circumstances make them vulnerable:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

However :

- One of the GPs and the health care assistant attended meetings with the integrated neighbourhood team to discuss, assess, plan and deliver care and treatment of the most vulnerable patients that had been identified.

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

This population group was rated inadequate because the impact from all the domains impacted on this population group overall. However :

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 95%. This was higher than the CCG and national averages of 89%.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 88% compared to the CCG average of 83% and the national average of 81%.

Monitoring care and treatment

There was no planned programme of improvement activity and the practice had not routinely reviewed the effectiveness and appropriateness of the care provided. There was no individual lead for the management of clinical audit. Only one of the GP partners had completed a two cycle audit which was on new cancer diagnosis that had been adopted by the Clinical Commissioning Group (CCG). They had identified that bowel, breast and cervical screening was low largely due to a cultural matter but no formal promotion campaign had been introduced to explain the importance of this screening and try and encourage individuals to attend.

We were told by one of the GPs about medicine management bar charts for example in antibiotic prescribing, but there was no regular medicine audits and no added input from a pharmacist who could assist and highlight any required changes in patient treatment.

The most recent published Quality Outcome Framework (QOF) results were 83% of the total number of points available which was lower than average when compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. The overall exception reporting rate was 3% which was lower than the CCG average of 5% and the national average of 7%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice had used some information about care and treatment to attempt to make improvements but these were not yet achieved. The percentage of patients with asthma, on the register, who had received an asthma review in the preceding 12 months that included an assessment of asthma control using the 3 RCP questions was 61% compared to the CCG average of 74% and the national average of 75%. The GPs told us they hoped this would improve because the practice nurse had now completed training in this area.
- One of the GPs had a special interest and was the lead for diabetes at the practice. They provided an audit that demonstrated improvement in their diabetic patients. However, the QOF results for 2016/2017 showed that the practice was performing much lower than the local and national averages for the required interventions with patients who have this long term condition. For example they had achieved 57 out of 86 possible points. This was 22% below the CCG average and 25% below the England average.
- One of the GPs was involved in a pilot to provide support for Asian women at risk of post-natal depression.

Effective staffing

Inadequate

Are services effective?

(for example, treatment is effective)

Not all the staff had the skills, knowledge and experience to carry out their roles. More than one member of staff was working in excess of their competencies and had no protocols to follow.

- The practice had not identified the learning needs of staff or provided protected time and training to meet them. There was no up to date records of skills and qualifications and no documents to evidence how training was maintained.
- Three members of staff had never worked in a GP practice before and had not received a satisfactory induction or satisfactory monitoring to ensure they understood the boundaries of their roles.
- Staff had not received ongoing support. We saw no evidence of formal induction, one-to-one meetings, coaching and mentoring, clinical supervision or support within the practice for revalidation. Only a small number of staff had revieved any form of appraisal.
- The healthcare assistant had completed the requirements of the Care Certificate but the practice had not ensured the competencies of that member of staff or other staff employed.
- There was a significantly poor approach to supporting and managing staff when their performance was variable.

Coordinating care and treatment

There was some evidence that staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that the integrated neighbourhood team was involved in discussing, assessing, planning and delivering care and treatment of the most vulnerable patients that had been identified. However not all patients received coordinated and person-centred care. Only one of the GPs was aware that care plans were in use at the practice and there was no evidence that the practice worked with patients to develop personal care plans that were shared with relevant agencies.
- We were not satisfied from speaking to one of the GPs that they understood how to contact and share information with the out of hour's services.
- There was evidence that not all the GPs ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

We did not see that all staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. However we saw evidence that not all the GPs met together on a regular basis to discuss this vulnerable patient group.
- The percentage of new cancer cases that were referred using the urgent two week wait referral pathway was 50% and this was in line with the CCG and national averages of 51%.
- One of the GPs was the lead for diabetes and saw all the patients with this long term condition. There was also a health trainer who came in to the practice once a week to see these patients and assist them with management of their long term condition. The practice nurse was not yet trained to carry out this intervention with patients.
- One of the GPs was involved in a pilot to provide support for Asian women at risk of post-natal depression.

Consent to care and treatment

Not all of the staff were able to demonstrate how they obtained consent to care and treatment in line with legislation and guidance.

- One of the GPs did not understand the question when asked if they obtained consent in line with the requirements of legislation and guidance. For example they could not demonstrate how they would apply Gillick competencies which ensure that young people are given the opportunity to make informed decisions without the consent of an older adult.
- One of the GPs administered join injections but they were unable to provide any consent forms or demonstrate how consent was obtained.
- Staff did not have up to date mental capacity act training.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for caring.

The practice was rated requires improvement because the impact from the safe, effective, responsive and well led domains overlapped into the caring element. In addition the practice was lower than average for all its satisfaction scores on consultations with GPs and nurses.

Kindness, respect and compassion

We saw that all staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All 15 patient Care Quality Commission comment cards we received were positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and the GP patient survey.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 380 surveys were sent out and 114 were returned. This represented about 2% of the practice population. The practice was lower than average for all its satisfaction scores on consultations with GPs and nurses. For example:

- 80% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 74% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 75% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 85% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 85% of patients who responded said the nurse gave them enough time; CCG - 92%; national average - 92%.
- 88% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 82% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 86% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Involvement in decisions about care and treatment

Staff we spoke with told us they tried to help patients to be involved in decisions about their care. They knew that they had to help patients as much as possible but they did not understand the term Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. In addition there were many multi lingual staff who could speak the languages of the most common spoken groups. The patient electronic attendance screen had instructions in most languages.
- Staff did identify that there were a large number of eastern European patients. However there were no notices in the reception areas in languages other than English, informing patients that an interpretation service was available.
- We were shown other methods of communication that staff used such as the Big Word NHS telephone interpreting service.

The practice had identified patients who were carers and had a carers register but there was no evidence that they were pro-active in providing any specific services for this patient group.

Results from the national GP patient survey showed patients did not respond very positively to questions about their involvement in planning and making decisions about their care and treatment. Results were lower than local and national averages:

Requires improvement

Are services caring?

- 70% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 71% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 84%; national average - 82%.
- 81% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 90%; national average - 90%.
- 75% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998 although we saw that a number of staff had not signed a confidentiality agreement.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as inadequate for providing responsive services.

The practice was rated as inadequate for providing responsive services because:

- The needs of the local population were not fully identified or taken into account when planning services, for example in the case of cervical, bowel and breast cancer screening. Some people were not able to access services for assessment, diagnosis or treatment when they needed to and action to address this was not timely or effective.

Responding to and meeting people's needs

- The practice were reactive rather than proactive when delivering services to meet patients' needs and the evidence we obtained indicated that patients' needs and preferences could not always be taken into account. This was because not all the staff had the necessary knowledge, training or understanding of certain circumstances such as Gillick competencies (a way of allowing very young patients to make their own decisions), safeguarding and mental capacity.
- There was evidence that the practice had made it difficult for patients to access the premises in the mornings because they were opening late. This was something that happened over a lengthy period and was not addressed until patients complained to the local media.
- The practice understood the needs of its population but services were not tailored in response to those needs. For example, cervical, bowel and breast screening was low due to the diverse beliefs within the population groups. There was no proactive or tailored plan to increase uptake of those important screening tests.
- There was no evidence that the practice had improved services where possible in response to unmet needs although we did note that one of the GPs had recently made themselves aware of domestic abuse and what to do in the event of any cases.
- The facilities and premises were appropriate for the services delivered except the front doors which were heavy and did not have a bell or assisted entry for patients with disabilities, those who were elderly and those with pushchairs.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services when required.

Older people:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall. In addition, the needs of this population group were not fully identified or taken into account when planning services. For example :

- There were very low numbers of patients over the age of 50 years in the practice population and no patients registered that lived in care homes or residential homes.
- Home visits did take place when necessary for older or housebound patients.

People with long-term conditions:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

- In addition, the needs of this population group were not fully identified or taken into account when planning services. For example there was no formal process in place for call and recall of patients with long-term conditions to ensure that they received an annual review to check to review their health and medicines needs. These reviews happened opportunistically when patients attended. However one of the GPs was the lead for diabetes patients and a health care worker did attend the practice on a weekly basis for patients with that particular chronic illness.
- The practice nurse did not support patients with long term conditions. Asthma screening was low and although the practice nurse had completed training in management of this condition recently, they had not had the time at the practice to complete their portfolio.

Families, children and young people:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- In addition, the needs of this population group were not fully identified or taken into account when planning services. In the case of cervical, bowel and breast cancer screening there were no forward thinking plans or ways to encourage increase in the uptake of these important screening tests.

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

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

- In addition, the needs of this population group were not fully identified or taken into account when planning services. For example, people had been unable to access the service in the early morning due to the late opening of the practice and this was not addressed until patients reported the issue to the local media.

People whose circumstances make them vulnerable:

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

- In addition there was no evidence of formal registers of vulnerable patients although there were red flags on some patient records to highlight those with specific additional needs. Patients were referred to the Integrated Neighbourhood Team individually by whichever clinician saw them but they were not routinely discussed within the practice at practice meetings so that all clinicians were aware of their needs.

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

This population group was rated inadequate because the impact from all the domains impacted on this population group overall.

- In addition when we discussed mental capacity and deprivation of liberty safeguards with the GPs one of them was very limited in their understanding of this subject which could be necessary in order to meet the needs of people showing signs of early on-set dementia.
- Not all the staff interviewed had a good understanding of how to support patients with mental health needs and clinical staff had not been trained in mental capacity.
- There were no practice held GP led dedicated monthly mental health or dementia clinics and no registers or formal recall for patients with mental health problems who did not attend appointments.

Timely access to the service

Patients were not always able to access care and treatment from the practice within an acceptable timescale for their needs.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was low compared to local and national averages. 380 surveys were sent out and 114 were returned. This represented about 2% of the practice population.

- 75% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 81% and the national average of 76%.
- 68% of patients who responded said they could get through easily to the practice by phone; CCG – 78%; national average - 71%.
- 74% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 84%; national average - 84%.
- 73% of patients who responded said their last appointment was convenient; CCG - 82%; national average - 81%.
- 70% of patients who responded described their experience of making an appointment as good; CCG - 76%; national average - 73%.
- 53% of patients who responded said they don't normally have to wait too long to be seen; CCG - 61%; national average - 58%.

Listening and learning from concerns and complaints

The practice had a complaints procedure and the practice manager was the person who dealt with all complaints. There was evidence that not all complaints and concerns were taken seriously and responded to appropriately to improve the quality of care. This was noted particularly in respect of the opening hours because despite several complaints from many patients and requests from staff, the matter was not dealt with by the person responsible until patients themselves took action.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

At the time of the inspection there was information about how to make a complaint but staff did not know what to do about complaints because the practice manager had left and there was no one person with overall responsibility in that area.

The practice did not all meet together to learn lessons from individual concerns and complaints and there was no formal analysis of trends.

Are services well-led?

Inadequate

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

Our findings

We rated the practice, and all of the population groups, as inadequate for providing a well-led service.

The practice was rated as inadequate for well-led because Leaders did not have the necessary experience, knowledge, capacity or desire to lead effectively and were out of touch with what was happening during day-to-day services. There was a lack of clarity about authority to make decisions and quality and safety were not top priority.

Leadership capacity and capability

Leaders did not work effectively together or consistently have the capacity and skills to deliver high-quality, sustainable care.

- Leaders could not evidence that they consistently had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were not knowledgeable about issues and priorities relating to the quality and future of services. They could not demonstrate an understanding of the challenges or show how they were addressing them.
- Leaders independently of each other were visible and approachable but they did not work together or closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- There were no effective processes to develop leadership capacity and skills or any planning for the future leadership of the practice.

Vision and strategy

There was no shared vision or strategy for the future of the practice and no forward thinking plan. All staff were reactive to whatever happened on any one given day.

Culture

On the day of the inspection the staff at the practice told us that there was a culture to deliver high-quality sustainable care.

- Administration staff stated they felt respected, supported and valued. They were proud of what they had achieved since they had joined the practice.
- Individually all clinical and administration staff told us that the practice focused on the needs of patients. However the behaviour and performance of the leaders did not demonstrate that.
- Openness, honesty and transparency was not always demonstrated when responding to incidents and complaints. In one example one of the leaders "declined to comment" and there were no formal systems in place to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with said they had until recently been able to raise concerns with the practice manager and were encouraged to do so. However now the practice manager had left they were unsure of the procedure going forward.
- There were no processes for providing all staff with the development they needed. There was no appraisal and career development conversations. Not all staff had received an appraisal and they were not supported to meet the requirements of their professional development.
- The practice nurse and health care assistant (HCA) did not have protected time for professional development, mentoring and evaluation of their clinical work.
- There was little emphasis on the safety and well-being of all staff and staff had not received equality and diversity training.
- Despite all the above there were positive relationships between staff and teams.

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were not clearly set out, understood or effective. The governance and management of partnerships, joint working arrangements and shared services did not promote interactive and co-ordinated person-centred care.
- Staff were not clear on their roles and accountabilities specifically in respect of safeguarding and infection prevention and control
- There were out of date and inconsistent policies, procedures and activities that did not ensure safety and there was no one monitoring those policies to be sure they were operating as intended.

Managing risks, issues and performance

Are services well-led?

Inadequate

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

There were no clear, consistent or effective processes for managing risks, issues and performance, particularly since the practice manager had left the practice.

- There was no effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- There were no processes to manage current and future performance.
- There was no process to check the performance of staff and support them in their roles. There was no mentoring of clinical staff through audit of their consultations, prescribing and/or referral decisions.
- There was no one with overall oversight of MHRA alerts, incidents and complaints and no one person responsible for those duties since the practice manager had left.
- There was no regular clinical audit to show positive impact on quality of care and outcomes for patients. There was no clear evidence of action to change practice to improve quality.
- There were no plans in place for staff training.

Appropriate and accurate information

The practice did not always act on information about the services provided.

- The leaders could not demonstrate that they had regular clinical meetings together to discuss the quality and sustainability of the practice. They were unable to show minutes of any clinical meetings since May 2017 although they said they had met and discussed matters of importance. No one was able to find minutes of meetings on the shared drive that were accessible to all staff.
- Arrangements in place around confidentiality of patient information were not robust enough because not all staff had read and signed a confidentiality agreement.
- Quality Outcomes Framework data was used to measure performance information. Some of the data had identified weaknesses which was in relation to low asthma reviews and there were plans to address this. There was no evidence of plans to address other low data such as cervical, breast and bowel screening.

Engagement with patients, the public, staff and external partners

The practice did not involve patients, the public, staff and external partners to support high-quality sustainable services. There was no active patient participation group and meetings with the clinical commissioning group had not been productive in ensuring that services were shaped and delivered in a way that met the needs and requests of the patient population.

Continuous improvement and innovation

The systems and processes for learning, continuous improvement and innovation were inadequate.

- The focus on continuous learning and improvement at all levels within the practice was not a priority. Reception and clinical staff did not have the necessary training to carry out their roles efficiently. Training they had not received included safeguarding (at various levels), mental capacity, infection control, health and safety and incident reporting.
- Clinical staff that had been on training courses did not have their competencies checked and did not have protected time to complete their portfolios.
- The practice did not made use of internal and external reviews of incidents and complaints to improve their services and there was no encouragement to take time out to review their team objectives. When staff had formally requested training at a meeting there was a response recorded in the minutes that it would be “done when there was time”.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users **How the regulation was not being met** The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular there was no formal review, discussion and learning from significant incidents to ensure that any errors did not reoccur. Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular, with regard to clinical and reception staff who were working outside their competencies and had not received appropriate training. The premises being used to care for and treat service users was not being used in a safe way. In particular there was no regular health and safety checks including fire, gas and electrical safety. There was no proper and safe management of medicines. In particular with regard to the way prescriptions were issued and authorised. There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular there was no overseen management of infection control and staff had not been trained appropriately. **Regulation 12(1)**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users must be protected from abuse and improper treatment **How the regulation was not being met** The registered person had failed to establish systems to prevent abuse. In particular with regard to ensuring that all staff, including clinical staff, were appropriately trained to the correct levels. **Regulation 13(1)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met** There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular : There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. There were no systems or processes that enabled the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular there was no active patient participation group. There was no regular clinical or administerial meetings where actions were taken forward and reviewed to ensure they had been completed.

This section is primarily information for the provider

Enforcement actions

There was no regular audit programme.

Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons **How the regulation was not being met** The registered person had failed to take such action as is necessary and proportionate to ensure that persons employed remained of good character. In particular : The documents in the personnel files were inconsistent with those required under Section 36 of the regulation. There was no evidence of DBS checks, photographic identification, references or history of previous employment in at least three of the personnel files that were reviewed. The registered person had failed to take such action as is necessary and proportionate to ensure that persons employed continued to have the qualifications, competence, skills and experience necessary for the work to be performed by them. In particular: • There was no formal induction programme, no training programme and evidence that staff had not received training appropriate to the roles they performed. **Regulation 19(1)&(5)**