Dr Rajesh Pandey

Quality Report

83 Priory Road
Hastings
East Sussex
TN34 3JJ
Tel: 01424 430800
Website: www.prioryroadsurgery.co.uk

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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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Rajesh Pandey on 8 December 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe services and being well led. It was also inadequate for providing services for all of the population groups. Improvements were also required for providing effective and responsive services. It was good for providing caring services.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice had not ensured systems and processes were established and operated effectively to prevent abuse of service users as staff were not up to date with safeguarding training and there was no internal safeguarding policy.
- Staff were not consistently supported to enable them to fulfil the requirements of their role. For example mandatory staff training was out of date in a number of areas, not all staff had received an annual appraisal and continuing professional development plans were not in place.
- The GP did not obtain written consent for invasive procedures such as joint injections and patients were not sufficiently informed of the risks or complications of the procedure and any alternatives.
- The practice did not have effective systems in place to ensure safe care and treatment for patients. For example, the practice did not have robust recruitment policies and procedures in place and appropriate recruitment checks on staff had not been undertaken. The practice had not undertaken DBS checks or a risk assessment on staff undertaking chaperone duties and joint injections were being carried out by a GP who had not received appropriate training. The practice did not ensure the surgery was adequately clean and comprehensive infection control procedures were not in place or carried out, including risk

assessments for legionella, staff training and regular audit. The practice did not have a procedure in place for the control of substances hazardous to health (COSHH) and did not have relevant data sheets in place relating to this. There was no medicine management policy or cold chain procedure in place, medicines and blank prescriptions were not stored securely and there was not an adequate system in place to manage high risk medicines. The practice could not demonstrate they were equipped for dealing with emergencies as they did not have oxygen and basic life support training was out of date.

- The practice did not have in place good governance systems. For example there was not a comprehensive system in place for appropriate environmental risk assessment such as fire safety and evacuation, disability access, use of equipment and not having emergency oxygen or a defibrillator on site. The practice did not have a system in place to ensure appropriate policies were available to staff and where policies were available they were not consistently reviewed and updated. The practice did not have a patient participation group (PPG) in place and had not acted on the results of the national GP patient survey that showed a lower than average score in terms of GP consultations. Staff were not clear about reporting significant events and there was limited evidence of significant event analysis, learning and communication with staff. There was no evidence of the practice having a comprehensive audit plan in place.
- The practice achieved an overall QOF (quality and outcomes framework) score relating to patient outcomes that was in line with local and national figures.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Urgent appointments were usually available on the day via a walk in clinic and patients were generally able to access non-urgent appointments within a week.

The areas where the provider must make improvements are:

- Ensure that staff are up to date with safeguarding training and that there are appropriate safeguarding policies, procedures and practices in place.
- Ensure that mandatory staff training is up to date in all areas, that all staff receive an annual appraisal and that continuing professional development plans are in place.
- Ensure that written consent is obtained for invasive procedures such as joint injections and patients are sufficiently informed of the risks or complications of the procedure and any alternatives.
- Ensure robust recruitment policies and procedures are in place and appropriate recruitment checks on staff are undertaken prior to recruitment.
- Ensure that DBS checks or a risk assessment is carried out on staff undertaking chaperone duties and that GPs are appropriately trained to carry out clinical procedures.
- Ensure the surgery is adequately clean and that comprehensive infection control procedures are in place and carried out, including risk assessments for legionella, staff training and regular audit.
- Ensure there is a procedure in place for the control of substances hazardous to health (COSHH) and that relevant data sheets are in place relating to this.
- Ensure that a medicine management policy and cold chain procedure are in place, that medicines and blank prescriptions are stored securely and that there is an adequate system in place to manage high risk medicines.
- Ensure that the practice is equipped for dealing with emergencies by ensuring oxygen is available and that staff have up to date basic life support training.
- Ensure there is a comprehensive system in place for appropriate environmental risk assessment such as fire safety and evacuation, disability access, use of equipment and not having emergency oxygen or a defibrillator on site.
- Ensure that appropriate policies are available, reviewed and updated in line with local and national guidance.
- Ensure that a patient participation group (PPG) is in place and that results of the national GP patient survey are acted on, particularly in relation to lower than average scores in terms of GP consultations.
- Ensure staff are clear about reporting significant events and that significant event analysis, learning and communication with staff takes place.
- Ensure there is a comprehensive audit plan in place to drive improvements in patient outcomes.

Summary of findings

The areas where the provider should make improvement are:

- Ensure that chaperone notices are visible in consulting and treatment rooms.
- Ensure that patients are appropriately screened for dementia in line with national guidance.

I am placing this practice in special measures. Practices 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 practice 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 vary the provider's registration to remove this location or cancel the provider's registration. Special measures will give people who use the practice the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff were not clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example, recruitment practices were not in line with best practice guidance, infection control processes were not in place, medicine management policies were not in place and medicines were not stored securely, areas of risk had not been identified and subsequently managed, equipment was not in place for medical emergencies and the practice did not have fire safety procedures (including drills, evacuation plan and training) in place. There was insufficient information to enable us to understand and be assured about safety because the practice did not have appropriate systems in place.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were comparable with local and national figures. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent. Processes for recording consent were unclear and there was limited understanding within the practice about the Mental Capacity Act (2005) and how this impacted on decision making regarding patients who did not have capacity to consent. The GP had not attended training or updates relating to the administration of joint injections.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Requires improvement 

The practice is rated as requires improvement for providing responsive services. The practice had reviewed the needs of its local population and feedback from patients reported that access to appointments and continuity of care was available. The practice had not undertaken a disability access assessment. Staff had not attended equality and diversity training. Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate 

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was a leadership structure in place with named members of staff in lead roles. However it was not clear how effective the structure was in terms of supporting safe care as staff had not always received up to date training for their lead roles and while staff felt listened to, changes were not always made in a way that valued the input of staff. The practice had a number of policies and procedures to govern activity, but many of these were over four years old and had not been reviewed since. There were other areas of practice where policies were not in place e.g. medicines management and maintaining the vaccination cold chain. The practice did not have a comprehensive or adequate approach to the management of risk . The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG). Staff told us they had not received regular performance reviews and did not have clear objectives.

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

Due to the issues identified within the practice the service is rated as inadequate for the care of older people. Care and treatment of older people reflected current evidence-based practice, and the majority of older people had care plans where necessary. The practice had visited 85% of people over the age of 75 to discuss care planning. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were generally good. However, diabetes and dementia performance indicators were below average. Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.

People with long term conditions

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of people with long-term conditions. Longer appointments and home visits were available when patients needed them. Structured annual reviews were undertaken to check that patients' health and care needs were being met.

Families, children and young people

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of families, children and young people. Immunisation rates were relatively high for a number of the standard childhood immunisations. For example childhood immunisation rates for the vaccinations given to under twos ranged from 96% to 100% and five year olds from 89% to 96%. These were comparable to CCG averages. Patients told us that children and young people were treated in an age-appropriate way.

Working age people (including those recently retired and students)

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of working-age people (including those recently retired and students).Services reflected the needs of this population group with flexible appointments via a walk in clinic and a weekly extended hours clinic for patients unable to attend during the working day. However, appointments could only be booked by telephone and online services were not yet available. Health checks were available for patients and the practice monitored the uptake of these.

Summary of findings

People whose circumstances may make them vulnerable

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice did not hold a register of patients living in vulnerable circumstances although they believed that as a small practice they knew who these patients were. It was unable to identify the percentage of patients who had received an annual health check.

The practice had worked with multi-disciplinary teams in the case management of vulnerable people. Although there was not an up to date policy in place and training was out of date clinical staff knew how to recognise signs of abuse in vulnerable adults and children, and they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies. The practice held a fortnightly substance misuse clinic for its patients at the practice.

People experiencing poor mental health (including people with dementia)

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The practice was able to identify patients experiencing poor mental health, however their dementia diagnosis rate was lower than average and they told us they did not screen patients for dementia when they lived in care homes. It had worked with multi-disciplinary teams in the case management of people experiencing poor mental health. Staff had not attended training in and were not consistently or adequately clear about the Mental Capacity Act (2005) and there was evidence that decision making did not consistently follow a best interest structure.

The practice had told patients experiencing poor mental health about support groups and voluntary organisations and they referred patients to a wellbeing service.

Summary of findings

What people who use the service say

The national GP patient survey results published on 8 July 2015 showed the practice was performing above the local and national averages in a number of areas including getting through to the practice by phone and accessing appointments. The area where the practice performed below average was in patients having to wait 15 minutes or less after their appointment time. However, the practice ran a morning walk in clinic where patients could be seen without an appointment but would generally have to wait to be seen. There were 107 responses and a response rate of 31%.

- 97% found it easy to get through to this surgery by phone compared with a clinical commissioning group (CCG) average of 77% and a national average of 73%.
- 96% found the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 93% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 90% and a national average of 85%.
- 97% said the last appointment they got was convenient compared with a CCG average of 94% and a national average of 92%.
- 94% describe their experience of making an appointment as good compared with a CCG average of 80% and a national average of 73%.
- 55% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 66% and a national average of 65%.
- 63% feel they don't normally have to wait too long to be seen compared with a CCG average of 62% and a national average of 58%.

97.5% of respondents in the practice friends and family test said they would recommend the service to their friends and family.

39 CCQ comment cards were completed and all were positive about the practice. For example we were told that staff were caring, friendly and patient and that the GP a good listener. All patients told us they felt their privacy and dignity was respected.

On the day of inspection we spoke to six patients. All told us they were happy with the service they received and that getting appointments when they needed them was not a problem. Two patients we spoke with told us they had stayed with the GP despite having moved closer to other practices because they were happy with the care and treatment they received.

Areas for improvement

Action the service MUST take to improve

- Ensure that staff are up to date with safeguarding training and that there are appropriate safeguarding policies, procedures and practices in place.
- Ensure that mandatory staff training is up to date in all areas, that all staff receive an annual appraisal and that continuing professional development plans are in place.
- Ensure that written consent is obtained for invasive procedures such as joint injections and patients are sufficiently informed of the risks or complications of the procedure and any alternatives.
- Ensure robust recruitment policies and procedures are in place and appropriate recruitment checks on staff are undertaken prior to recruitment.
- Ensure that DBS checks or a risk assessment is carried out on staff undertaking chaperone duties and that GPs are appropriately trained to carry out clinical procedures.
- Ensure the surgery is adequately clean and that comprehensive infection control procedures are in place and carried out, including risk assessments for legionella, staff training and regular audit.
- Ensure there is a procedure in place for the control of substances hazardous to health (COSHH) and that relevant data sheets are in place relating to this.

Summary of findings

- Ensure that a medicine management policy and cold chain procedure are in place, that medicines and blank prescriptions are stored securely and that there is an adequate system in place to manage high risk medicines.
- Ensure that the practice is equipped for dealing with emergencies by ensuring oxygen is available and that staff have up to date basic life support training.
- Ensure there is a comprehensive system in place for appropriate environmental risk assessment such as fire safety and evacuation, disability access, use of equipment and not having emergency oxygen or a defibrillator on site.
- Ensure that appropriate policies are available, reviewed and updated in line with local and national guidance.
- Ensure that a patient participation group (PPG) is in place and that results of the national GP patient survey are acted on, particularly in relation to lower than average scores in terms of GP consultations.
- Ensure staff are clear about reporting significant events and that significant event analysis, learning and communication with staff takes place.
- Ensure there is a comprehensive audit plan in place to drive improvements in patient outcomes.

Action the service SHOULD take to improve

- Ensure that chaperone notices are visible in consulting and treatment rooms.
- Ensure that patients are appropriately screened for dementia in line with national guidance

Dr Rajesh Pandey

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 and a practice manager specialist advisor.

Background to Dr Rajesh Pandey

Dr Rajesh Pandey offers general medical services to people living and working in Hastings.

Dr Rajesh Pandey is a single handed practice with one GP providing 10 sessions a week and locum cover for holiday and training cover. There are approximately 2600 registered patients.

The surgery is open from 08:00am to 6:30pm Monday to Friday. Appointments are available via a walk in clinic between 8.45am and 10.30am from Monday to Friday and appointment only sessions on a Monday, Tuesday, Thursday and Friday from 4.00pm am to 6.00pm. Extended hours surgery appointments are available between 6.30pm and 8.00pm on a Tuesday by appointment

There is a full time practice manager, a part time practice nurse working four hours a day, four days a week between 8.30am and 12.30pm, and four administrative/reception staff.

The practice runs a number of services for its patients including asthma clinics,child immunisation clinics, diabetes clinics, new patient checks, and weight management support.

Services are provided from:

83 Priory Road,

Hastings,

East Sussex,

TN34 3JJ.

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider (111).

The practice population has a marginally higher number of patients under the age of 18 and less patients over the age of 65 compared with the England average. The practice population also has a slightly higher number of patients compared to the national average with a long standing health condition, those with health related problems in daily life and those claiming a disability allowance. The practice population has more than twice the levels of unemployment compared to the national average.

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. This inspection was planned to check whether the provider was 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

Detailed findings

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Hastings and Rother Clinical Commissioning Group (CCG). We carried out an announced visit on 8 December 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, and administration staff.

We observed staff and patients interaction and talked with three patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 39 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not adequately prioritise safety or use information to identify risks and improve patient safety. For example, reported incidents were not always adequately addressed. The staff we spoke with were aware of their responsibilities to raise concerns, however not all incidents were recorded and there was not a clear system in place to identify incidents and near misses and appropriately review them. For example one member of staff told us of an incident where a patient fainted during a procedure and while they told us this had been reported to the GP there was no record available and while the staff member told us of changes they had made to their own practice as a result, there was no evidence of discussions or learning.

We did not see safety records, incident reports and minutes of meetings where significant events were discussed. This showed the practice had not managed these consistently over time and could not show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice did not have a system in place for reporting, recording and monitoring significant events, incidents and accidents. A new accident/incident book had been implemented in the weeks prior to our visit. The practice sent us one written record of a significant event as part of the information provided prior to inspection. The report detailed an incident relating to a patient becoming aggressive in the consulting room. We saw that action taken included placing a poster regarding the practice's zero tolerance of violence and aggression and discussion with staff. However, there was no panic alarm installed in the practice at the time of the incident and the practice had not undertaken a risk assessment or considered that a panic alarm may be a useful way to reduce the risk of harm in the future. Practice staff were unaware of a panic alarm feature on the new electronic system that had been implemented. Significant events was not a standing item on the practice meeting agenda and there was no dedicated meeting held to review actions from past significant events and complaints. There was limited evidence that the practice had learned from significant events or that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, told us they felt able to raise an issue for consideration by the GP and practice manager however there was limited evidence of whole staff discussion or involvement.

Staff were not aware of incident forms on the practice intranet although they were aware there was an accident/incident book kept in the nurses room. Because of limited reporting and recording of incidents it was unclear if, when patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken to prevent the same thing happening again. Practice staff and management did not have a clear understanding of the duty of candour.

National patient safety alerts were disseminated by a receptionist who had been tasked with medicines administration and GP to practice staff. We saw evidence of personal alerts relating to specific patients as part of the electronic patient record system.

Reliable safety systems and processes including safeguarding

The practice did not have adequate systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that not all staff had received relevant role specific training on safeguarding. Training on child safeguarding had been completed and the GP was trained to level three, however no staff had attended training in vulnerable adult safeguarding. Staff we spoke with had some understanding of how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and signposted us to contact details for the relevant agencies in working hours and out of normal hours. However, there was no internal safeguarding policy.

The GP was the lead in safeguarding vulnerable adults and children. They had been trained in child safeguarding only and had not attended an update in two years. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records, however this was a new system and not yet been fully utilised. We saw evidence of some alerts for individual patients however the practice manager told us there were a small number of vulnerable patients and that as a small practice staff knew who the

patients were. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was an undated chaperone policy in place and we saw a visible notice on the waiting room noticeboard informing patients of the availability of a chaperone. There were no chaperone notices visible in the 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). The practice nurse had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Not 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). There was not a risk assessment in place for staff without a DBS check who carry out the role of chaperone.

The system for reviewing repeat medications for patients with co-morbidities/multiple medications involved a regular comprehensive review by the GP. The GP offered follow up appointments to patients on discharge from hospital dependent on need. The practice did not utilise a vulnerable adult register although they maintained comprehensive care plans for patients at risk, including those at risk of an unplanned hospital admission.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not always stored securely and only accessible to authorised staff. The vaccination fridge was unlocked and stored in a corridor just off the patient waiting area and outside of the nurse's consulting room. There was no policy for ensuring that medicines were kept at the required temperatures, and no clear description or plan for the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers and those for hand written prescriptions were not handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times. Blank prescription forms were kept in printers and not locked away.

We saw evidence of prescribing data reviews following CCG guidance. For example, we saw a review of the use of high dose corticosteroids in asthma patients although it was unclear from the data what action had been taken as a result of the review.

There was not a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. For example, the practice did not have a system in place to routinely check for relevant blood results before issuing repeat prescriptions for high risk medicines.

The nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in the past 12 months. We saw evidence that the nurse had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

We did not see evidence of reporting or learning from medicines incidents and errors. Staff told us they were not aware of any medicines incidents.

Cleanliness and infection control

Patients told us they observed the premises to be clean and tidy although we saw some evidence of dust and clutter in the minor surgery room. The nurse told us they had recently been made the lead for infection control and had been working through making improvements in disposing of old equipment that was no longer in use and generally reducing the amount of clutter in the practice. There were no cleaning schedules in place or cleaning

records kept. The practice had a cleaner once a week and the practice manager told us they informed them verbally of the areas they wished to be cleaned or focused on during each visit.

An infection control policy and supporting procedures were available for staff to refer to although this was out of date by more than two years and the infection control lead who was relatively new in post was not aware of them. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these. Infection control procedures were not being carried out in line with best practice. For example, curtains used in the clinical rooms were not disposable and had not been regularly laundered every six months. There was a procedure for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had recently appointed a lead for infection control although they had not yet undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. There was no evidence of staff having received annual infection control training updates such as handwashing. We saw evidence that the practice had carried out an audit in 2012 although we did not see evidence that any improvements identified for action were completed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice did not have a control of substances hazardous to health (COSHH) procedure in place and did not have relevant COSHH data sheets available for the materials they used. A bottle of cleaning liquid was visible on the worktop of the nurse's room and not kept in a locked cupboard.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings) and they had not undertaken a risk assessment relating to legionella or regular check to reduce the risk of infection to staff and patients).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. However, some equipment was dated or not entirely suitable for the purposes used. For example in the minor surgery room where the nurse undertook cervical cytology checks there was an examination couch that was not height adjustable. The practice had provided a step for patients to use to step up onto the couch although the step was not suitable for patients with mobility difficulties and the nurse told us they would sometimes have to help patients onto the couch. A lamp used by the nurse for performing cervical cytology checks was a standard domestic lamp and was not easily movable. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested although stickers were not consistently displayed following a test as some of these were out of date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice did not have a valid in-date recruitment policy in place that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at did not demonstrate 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 were not consistently carried out (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). For example, there was no evidence of identity checks, references, DBS or NMC checks having taken place for a practice nurse who had been working at the practice for several weeks. There was no evidence of identity checks, references or employment history for a recently recruited member of the administrative team. There was no evidence of a system in place to check DBS, employment history or medical defence cover for a locum who had worked at the practice.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement

in place for members of administrative staff, to cover each other's annual leave. Staff told us that cover for the nurse would sometimes be provided by nursing staff from neighbouring practices although the formality of this arrangement and evidence of appropriate checks was unclear.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice did not have robust systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was an undated health and safety policy in place but the practice did not undertake regular checks of the building or the environment. There were no environmental risk assessments in place and no risk log.

Staff gave examples of how they responded to patients experiencing a mental health crisis. Examples given included working with the police and community mental health services to keep patients safe and ensure they receive the treatment and care they need.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support although they had not all attended annual updates. There was no emergency equipment available such as access to oxygen and an automated external defibrillator (used in cardiac emergencies). The practice had not undertaken a risk assessment relating to this and we were told that the procedure in place in an emergency was to dial 999.

Emergency medicines were easily accessible to staff in the GPs consulting room and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. We saw records of regular checks although these were not consistently dated. 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. 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 plan was last reviewed in 2012. Staff told us that arrangements were in place to gain support from neighbouring practices in the case of emergency and that this included sharing staff and facilities when needed.

The practice had not carried out a fire risk assessment and did not have clear actions in place to maintain fire safety. For example the practice did not have an evacuation procedure in place, there was no fire alarm system, staff had not attended fire safety training and the practice did not undertake regular fire drills. We viewed records that demonstrated fire safety equipment such as fire extinguishers had been regularly maintained although it was unclear who within the practice was trained in their use. The practice had not undertaken a disabled access risk assessment, including the risk posed in the event of a fire or other emergency. Staff told us they had a number of patients in wheelchairs and that there was disabled access within the surgery. However, we saw that the fire exit from the building did not have ramp access and there were several steps to exit the building if the main entrance/exit was inaccessible.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. However we did not see evidence of NICE guidance being discussed at clinical meetings. The GP regularly attended meetings and educational sessions at the local CCG where relevant NICE guidance and local guidelines were shared and discussed.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GP told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met where appropriate.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP and nurse showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager.

The practice did not have a system in place for completing clinical audit cycles. The practice did not have a plan in place to identify areas for audit relating to practice based activities, patient risk or improving patient outcomes. For example we did not see audits relating to minor surgical procedures such as joint injections or cryotherapy or areas identified through significant event analysis.

The GP told us clinical audits they had undertaken were linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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). For example, we saw two prescribing audits that had been undertaken in the last year. One was an audit regarding the prescribing of pregabalin (a medicine for peripheral and central neuropathic pain). Following the audit, the GP carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice achieved 95.7% of the total QOF target in 2015, which was above the national average of 93.5%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was worse (83.7%) compared to the local average (93%) and national average (89.2%).

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients with hypertension having regular blood pressure tests was better (100%) compared to the local average (99.2%) and the national average (97.8%).
- Performance for mental health related and hypertension QOF indicators was better (97.1%) compared to the local average (84.4%) and the national average (81.5%).
- The dementia diagnosis rate was 0.48% below the national average and 0.73% below the local average at 0.25%.

The practice was aware of all the areas where performance was not in line with national or CCG figures although we did not see plans in place for how they were addressing this. In particular we asked the GP about dementia screening as the dementia diagnosis rate was low, they told us they did not screen patients who were resident in nursing or care homes.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with a learning disability or those with substance misuse issues. Structured annual reviews were also undertaken for people with long term conditions (e.g. Diabetes, COPD, Heart failure).

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example the GP told us they were aware their referral rate to secondary care was higher than average for the locality but that this had improved with a greater availability of community services.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending mandatory courses such as annual basic life support. For example staff had not regularly attended annual updates and the majority of staff had not had BLS training for a year and a half. The GP was up to date with their yearly continuing professional development requirements and either 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). However, the GP told us they had not attended specific training or regular updates relating to joint injections they were carrying out within the practice.

We saw evidence that some staff had received an annual appraisal that identified learning needs relating to the role they were undertaking although we did not see clear action plans documented as part of this process. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse had attended training in diabetes, asthma and COPD (chronic obstructive pulmonary disease) since commencing in post a few months before. The nurse had also shadowed the previous post holder and had been given the opportunity of working with a nurse from another local practice to build their confidence in areas of practice.

The practice nurse had also attended training on the administration of vaccines and cervical cytology as well as training relating to the management of long-term conditions.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with

Requires improvement

Are services effective?

(for example, treatment is effective)

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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively similar at 1.89% compared to the national average of 1.44%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and GP told us they reviewed the most vulnerable patients via a home visit following an unplanned hospital admission based on need.

The practice held multidisciplinary team meetings every two months to discuss patients with complex needs. For example, those with end of life care needs, mental health needs and those with multiple long term conditions. These meetings were attended by district nurses, social workers and mental health professionals. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and we saw evidence of this in use. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were trained on the system although the system had been changed in recent months and was not yet fully embedded. 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

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood some of the key parts of the legislation and were able to describe some aspects of how it was implemented. However, the practice did not have a policy for specific scenarios where capacity to make decisions was an issue for a patient. For example, clinical staff were not aware of and had not been involved in best interest meetings. We were told of a recent decision having been made without following a best interest process regarding a patient staying in a care home where they did not have capacity to be involved in the decision. We were given details by patients and staff alike of scenarios where the GP visited patients at home to discuss DNACPR (do not attempt cardiopulmonary resuscitation) decisions and end of life care planning.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us that 100% of care plans had been reviewed in the last year. All clinical staff demonstrated a clear understanding of the

Requires improvement

Are services effective?

(for example, treatment is effective)

Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was not a practice policy for documenting consent for specific interventions. For example, written consent for minor surgical procedures such as joint injections and cryotherapy was not sought. A patient's verbal consent was not documented in the electronic patient notes and there was not a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check 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 noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice had a process in place for following up patients if they had risk factors for disease identified at the health check and further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 97% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 87% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 77.5%, which was similar to the national average of 76.7%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 66.58%, and at risk groups 63.2%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 96% to 100% and five year olds from 89% to 96%. These were above/below/comparable to CCG/National averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included results from the Friends and Family Test where 97.5% of patients said they were likely or extremely likely to recommend the practice. We also reviewed information from the national patient survey from 8 July 2015.

The evidence from these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. However, the practice scored slightly below the CCG and national average in relation to consultations with doctors. For example:

- 83% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 84% said the GP gave them enough time compared to the CCG average of 87% and national average of 89%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 39 completed cards and they were all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There were no negative comments received via the CQC comment cards. We also spoke with six 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk although because the area was adjacent to the waiting room and space was limited conversations could sometimes be overheard. A radio had been placed in the waiting area and music was played to minimise the risk of conversations being overheard. Staff told us this had somewhat improved the situation. Additionally, 96% of GP patient survey respondents said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

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

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. For example, we saw records where patient involvement in end of life

Good

Are services caring?

care planning had been recorded. Similarly, one patient we spoke to at the practice told us the GP had visited them at home especially to discuss end of life care and decision making around DNACPR. The patient told us this had been dealt with sensitively and the GP had given them time to consider what they wanted and took their wishes into account. Patient feedback on the comment cards we received was also positive and aligned with these views.

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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

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

- 86% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice did not have a register of patients who were also carers although there was an information folder in the reception area of the practice providing support information to carers. This written information for carers to helped them to understand the various avenues of support available to them.

Staff told us that if families had suffered bereavement, the GP contacted them. There was evidence that staff would visit those patients at home who were isolated or found it difficult to get to the practice. Patients had access to a primary care mental health care worker and could be referred by the GP or could self-refer. We saw that the practice monitored referral data via the CCG.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice had some systems in place to maintain the level of service provided but that they were not always responsive to people's needs. The needs of the practice population were understood and some systems were in place to address identified needs in the way services were delivered. For example the practice offered a combination of walk in and appointment based appointments, including some extended hours appointments to meet the needs of a variety of population groups and individuals.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw that the GP regularly attended CCG meetings and we were told that there were good working relationships with other local practices that included some reciprocal arrangements in place for support.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and they ran a fortnightly clinic for patients with substance misuse issues where a specialist nurse attended the practice to provide support. 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.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level with the exception of the room used for the substance misuse clinic that was on the first floor. However, staff told us that if a patient with mobility problems needed to be seen in that clinic they would be able to accommodate them on the ground floor. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. However, the waiting area was very small, as were the corridors and while staff told us that patients in wheelchairs and mobility scooters could access the building there was limited space. This made movement around the practice difficult at times. The practice had not undertaken a disability access assessment and we identified particular problem with patients with mobility issues or in wheelchairs not being able to use the fire exits due to there being external steps out of the building. The main entrance/exit had wheelchair access via a ramp.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There was one male GP in the practice; therefore patients could not choose to see a male or female doctor. The practice were aware of the issues patients might face because of this and made it clear to patients when they registered that there was just one male GP.

The practice did not provide equality and diversity training. Staff we spoke with told us that they had not completed equality and diversity training in the last 12 months and there was no evidence equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 08:00am to 6:30pm Monday to Friday. Appointments were available via a walk in clinic between 8.45am and 10.30am from Monday to Friday and appointment only sessions on a Monday, Tuesday, Thursday and Friday from 4.00pm am to 6.00pm. Extended hours surgery appointments were available between 6.30pm and 8.00pm on a Tuesday by appointment.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Online appointment booking was not yet available although this was something the practice was planning to do in the near future. 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with the GP or nurse. Home visits were made to those patients who needed one in between morning and afternoon surgeries.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 90% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 94% described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 55% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%.
- 97% said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 73%.

The practice offered walk in appointments to patients every morning and it was made clear to patients that they may have to wait to be seen. On the day of inspection patients told us they sometimes had to wait for up to an hour but that they were warned of this when accessing the walk in clinic and were told by staff to bring a book. Patients we spoke to told us they didn't mind waiting as they saw the walk in clinic as positive due to being able to see the GP when they needed to.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent. Routine appointments were available for booking six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, a number of patients we spoke to told us they had arrived at the practice for the walk in clinic or had called in the morning for an appointment in the afternoon.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice addressed issues arising from complaints and concerns as they occurred. However the practice did not have in place a formal process for identifying trends and themes as a result of complaints analysis and management.

We saw that information was available to help patients understand the complaints system including a poster displayed in the patient waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found that while an attempt to address the complaint and that patients were given an apology, the process was not always comprehensive or clearly documented. For example we saw that a patient had complained verbally about an issue relating to a problem with a prescription. The patient became abusive because the doctor was not available to address the issue so the action taken by the practice related to only managing patient access in the absence of the GP rather than addressing the cause of the concern in addition. A second verbal complaint had not been addressed in a timely way and had resulted in the patient formalising their complaint in writing.

The practice did not review complaints annually to detect themes or trends and there was limited evidence that improvements had been made to the quality of care as a result of the complaints management process.

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 had a clear vision to deliver high quality care and promote good outcomes for patients, however they did not have a strategy in place and we did not see documented values, a mission statement or objectives. During the inspection the GP and practice manager spoke of their future direction and told us of aims such as online appointment booking and repeat prescription requests, as well as the possibility of providing sexual health services in the future.

We spoke with five members of staff and they all shared the aim of high quality care and good outcomes for patients. However, it was unclear how staff were involved in developing the future direction of the practice.

Governance arrangements

The practice had some policies and procedures in place to govern activity. However a number of these were out of date and had not been reviewed or were undated so it was difficult to assess whether they had been appropriately reviewed. For example, whistleblowing, appraisal and patient referral policies were all undated. The infection control policy had not been reviewed since 2011 and a clear review date for 2013 had not been met and a cervical smear policy was dated 2009 and had not been reviewed. There was not a comprehensive medicines management or cold chain policy in place. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies that were undated or out of date. We were shown a paper copy of a staff handbook that had not been updated since 2010. Where policies were available to staff they were in paper form in a file in reception. However not all staff were aware of the policies, for example the nurse had not had sight of the infection control policy.

There was a leadership structure in place with named members of staff in lead roles, however it was not clear how effective the structure was in terms of supporting safe care. For example, there was a lead nurse for infection control and the GP was the lead for safeguarding although training for these roles either had not taken place or was out of date. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us the practice was a good place to work and they felt their views would be listened to and they knew who to go to in the practice with any concerns. However, some staff told us that changes were sometimes slow to be implemented.

The practice had not identified, recorded and managed risks. There were no environmental risk assessments recorded and no evidence of action taken to reduce risk in areas including legionella, fire safety and general building risks. We did not see evidence of risks being discussed at practice meetings although staff told us this was done in an ad hoc way as necessary.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. They included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. Staff told us that QOF data was regularly discussed.

While the practice had made use of clinical audits there was not a structured programme in place that demonstrated the use of audit to monitor quality and systems to identify where action should be taken. For example we saw evidence of prescribing incentive audits having been carried out but these were not full cycle audits used to demonstrate improvements. In addition, the practice had not identified internal quality areas where audit would be a useful tool to drive improvements.

The practice held ad hoc staff meetings where issues were discussed. We viewed minutes of a meeting held on 22nd October 2015 and saw that the next meeting was planned for three months later in January 2016 although we did not see a specific date for this. We looked at minutes and saw that while information was shared that performance, quality and risks had not been discussed.

Leadership, openness and transparency

The GP and practice manager were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. However, there was little evidence that staff were involved in discussions about how to run the practice and how to develop the practice.

Are services well-led?

Inadequate

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

We saw from minutes that team meetings were held infrequently with staff telling us these were ad hoc. We viewed minutes of a meeting dated 22 October 2015 and saw the next meeting was planned for three months later. Staff told us that they would raise any issues at directly with the GP and practice manager and that they felt listened to. The practice did not hold team away days.

Seeking and acting on feedback from patients, public and staff

The practice told us they encouraged and valued feedback from patients although they did not undertake their own patient survey and we did not see evidence of analysis or review of the results of the national GP patient survey The practice also did not have a patient participation group (PPG). However, it had gathered feedback from patients through the friends and family test (FFT) and patient feedback relating to the GP as part of their appraisal. This feedback was positive with 97.5% of patients stating they would recommend the practice..

The practice had not gathered feedback from staff through surveys. Although we saw some evidence of appraisal and staff meetings it was unclear how much staff were able to contribute to the development of the practice. Staff told us they felt that their views were listened to but that this did not always result in changes. For example a member of staff told us they fed back that the equipment was not appropriate for undertaking cervical smears, however a new light was then purchased without the input of staff using it and subsequently did not entirely meet the need. Other staff told us they felt their views were listened to but did not feel they were always acted upon.

Management lead through learning and improvement

There was some evidence of the practice supporting staff to maintain their clinical professional development through training. For example, the practice nurse who had been in post for a few months had attended a number of training courses in order to carry out her role. We looked at four staff files and saw that two staff had received appraisals in the days prior to our inspection and that other staff had not received an appraisal in more than two years. We did not see personal development plans in place for staff who had received an appraisal.

There was no evidence of the practice completing reviews of significant events and other incidents or sharing with staff at meetings and away days to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered provider had not ensured systems and processes were established and operated effectively to prevent abuse of service users. This was in breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to monitor and review the training, learning and development needs of staff to enable them to fulfil the requirements of their role. The provider had failed to operate a system for annual appraisal, including the use of personalised development plans for staff. This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the provider did not obtain written consent for invasive procedures such as joint injections and that patients were not sufficiently informed of the risks, complications of the procedure and any alternatives. This was in breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to comply with the proper and safe management of medicines. There was no medicines management or cold chain policy. Medicines were not stored securely within refrigerators. The provider had failed to implement a system to manage the risks associated with high risk medicines. We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to prevent, detect and control the spread of infections due to not assessing the risk from legionella bacteria.

This section is primarily information for the provider

Enforcement actions

The provider had failed to maintain an up to date infection control policy and audits and had failed to take action from previous audits. There was no cleaning schedule in place and there was visible dust and clutter in treatment areas within the practice.

The provider had failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

The provider had failed to assess the risk of not having emergency equipment such as a defibrillator and oxygen on the premises for use in an emergency.

This was in breach of regulation 12 (1) (2) (a) (b) (c) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider had not always assessed, monitored and mitigated the risks relating to the health safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. We found that the registered provider had not always assessed, monitored and improved the quality and safety of services provided. We found that the registered provider had not always taken action 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.

This section is primarily information for the provider

Enforcement actions

We found that the registered provider had not securely stored records in relation to the management of the regulated activity. The registered provider had not maintained records relating to the management of the regulated activity in the form of up to date and relevant policies and procedures.

We found that the registered provider had not always evaluated and improved their practice in respect of mitigating risk, improving the quality and seeking and acting on feedback on the services provided.

This was a breach of regulation 17 (1) (2) (a) (b) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had failed to assess whether an applicant was of good character and had not confirmed information about the candidate before being employed as set out on Schedule 3 of the Health & Social Care Act 2008 namely by not having completed a criminal record check through the Disclosure and Barring Service (DBS), checking identification, checking NMC registration or requesting references. .

This was a breach of Regulation 19(1)(a)(b)(2)(a)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.