The Friary Surgery

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Friary Surgery on 23 June 2016. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because the systems and processes in place were ineffective. We found concerns in relation to health and safety, management of safeguarding, recruitment of staff, medicines management, infection control and the ability to respond to clinical and non-clinical emergencies.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, lessons learned were not communicated widely enough to support improvement. There was no evidence of any improvement action plans.
- The practice kept up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The outcomes of patients' care and treatment were not always monitored regularly. Clinical audits were not routinely carried out to improve care, treatment and people's outcomes.
- Clinical and non-clinical staff had not received all of the training necessary to carry out their roles effectively.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Whilst complaints were responded to lessons learned and action taken was not sufficiently detailed to assure lessons had been learnt. Complaints were not monitored over time to enable the practice to look for trends and areas of risk that may be addressed.

Summary of findings

- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice did not have an overarching governance framework which supported the delivery of good quality care.
- The practice had no clear leadership structure and insufficient leadership capacity.

The areas where the provider must make improvement are:

- Ensure that incidents that may affect the health, safety and welfare of people using services, such as significant events or a complaint is recorded, reviewed and thoroughly investigated to prevent further occurrences.
- Ensure the proper and safe management of medicines.
- Ensure there are adequate systems in place for assessing the risk of, preventing, detecting and controlling the spread of infections, including those that are health care associated.
- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.
- Ensure patient records are securely maintained.
- Carry out clinical audits including re-audits to ensure improvements have been achieved and that guidance is being followed.
- Ensure staff receive appropriate support, including appraisal and training relevant to their role.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which is reflective of the requirements of the practice.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure an overarching governance framework which supports the delivery of good quality care is put in place.
- Ensure risks and issues are always identified and dealt with appropriately and in a timely way.

The areas where the provider should make improvement is:

- Ensure action is taken to proactively identify carers registered at the practice.

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 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.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, incidents were not always reported appropriately. When things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- The practice did not have a system in place for assessing the risk of, and preventing, detecting and controlling the spread of infections.
- The arrangements for managing medicines in the practice did not always ensure patients were safe. The practice could not demonstrate the process for repeat prescribing was safe.
- There was no evidence to show the provider always assessed the risks to the health and safety of service users and visitors to the practice. Where risks were identified, the practice did not always introduce measures to reduce or remove the risks within a timescale that reflected the level of risk and impact on people using the service. For example a fire risk assessment completed by an external company dated April 2015 highlighted areas of responsibility for the occupiers to address in February 2016 which had not been acted on.
- The practice did not always ensure appropriate recruitment checks were in place for staff.
- Patient paper records (Lloyd George) were stored in the main administration area in filing cabinets that were unlocked during the day. These were accessible from the main corridor via an unlocked door.

Are services effective?

Requires improvement

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

- The practice kept up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.

Summary of findings

- The outcomes of patients' care and treatment were not always monitored regularly. Clinical audits were not routinely carried out to improve care, treatment and people's outcomes.
- The practice could not demonstrate how they ensured oversight of role-specific training and updating for relevant staff. Staff received some training but we identified staff that had not completed training in a range of areas that included safeguarding adults, fire safety awareness, basic life support, infection control and information governance.
- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.
- Clinical staff were supervised but there was no supervision or appraisal process in place for non-clinical staff.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey showed patients rated the practice equal or slightly higher than the national average 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 saw staff treated patients with kindness and respect.
- We were told the practice was not proactive in reaching out to the wider practice population to encourage carers to register. Some of the clinicians were unclear whether there was a register of carers in place.

Are services responsive to people's needs?

Requires improvement

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

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and CCG to secure improvements to services where these were identified. The practice was part of the CCG Nursing Workforce Project and a Federation known as the Heartbeat Alliance. The practice had benefited from the services through the Federation of a pharmacist who was working at the practice.

Summary of findings

- Patients said they found it easy to make an appointment although not always with the same GP. Urgent appointments were available the same day.
- There were some disabled facilities available. Some areas of the practice were challenging for some population groups. For example, a steep ramped area down to some of the consulting rooms and steps to the rear fire exit. There were no action plans or risk assessments in place in respect of these issues. Some of the facilities were in need of repair or replacement, for example torn carpets and chairs.
- Information about how to complain was available and easy to understand. Whilst complaints were responded to and an apology given to the patient, the documentation lacked detail as to how complaints had been investigated. Lessons learnt and action taken was not sufficiently detailed to assure lessons had been learnt. Complaints were not monitored over time to enable the practice to look for trends and areas of risk that may be addressed.

Are services well-led?

Inadequate

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

- The practice did not have an overarching governance framework which supported the delivery of good quality care. Risks and issues were not always identified and if they were identified they were not always dealt with or dealt with in a timely way.
- The practice had a number of policies and procedures to govern activity; many of which we were told had been written or updated in the two weeks prior to the inspection. We found evidence that these were not always being followed by staff.
- Leaders did not demonstrate a clear understanding of their responsibilities under the HSCA or a clear understanding and awareness in respect of their current position at the practice.
- The majority of staff said they felt supported by management. However we were told that some staff, in particular the practice manager and some of the nursing staff did not have capacity to fulfil the requirements of their role. We were also told that issues had been raised with the partners but these were not responded to.
- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The

Summary of findings

duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Whilst these systems were in place these were not always followed.

- We were told there was a culture of openness and honesty. However we found issues recorded in the dispensary were not always being recorded as significant events.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people. The practice was rated as inadequate for safety and well led and requires improvement for being effective, caring and responsive. The issues identified affected all patients including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. As part of the Nursing Workforce Project the practice nurses were working with patients in local care homes and assisted housing schemes. Capacity to support this was made available by the recruitment of a part time health care assistant.
- The practice was responsive to the needs of older people, and offered home visits, health checks for the over 75s and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice was rated as inadequate for safety and well led and requires improvement for being effective, caring and responsive. The issues identified affected all patients including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the national average. The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) was 84% compared to the national average of 88%. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2014 to 31/03/2015) was 81% compared to the national average of 78%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being

Summary of findings

met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care to prevent unnecessary admission to secondary care.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The practice was rated as inadequate for safety and well led and requires improvement for being effective, caring and responsive. The issues identified affected all patients including this population group.

- The practice was in the process of re-establishing links with health visitors and school nurses. The practice system alerted staff to children recorded as living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 86%, which was comparable to the CCG average of 84% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered emergency contraception, family planning and sexual health advice including administration of all long-acting reversible contraceptives (LARCs).

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The practice was rated as inadequate for safety and well led and requires improvement for being effective, caring and responsive. The issues identified affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice was rated as inadequate for safety and well led and requires improvement for being effective, caring and responsive. The issues identified affected all patients including this population group.

- The practice held a register of patients who may be living in vulnerable circumstances such as those with a learning disability.
- The practice offered longer appointments for patients assessed as needing them.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Information was available on the practice website to direct carers to the various avenues of support available to them but there was no information in the practice waiting area.
- Staff demonstrated an understanding of safeguarding adults although not all staff were trained in this area. There was evidence that a safeguarding adults incident had not been appropriately responded to.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The practice was rated as inadequate for safety and well led and requires improvement for being effective, caring and responsive. The issues identified affected all patients including this population group.

- Mental health related indicators were higher than the national average. Exception reporting was less than half of the national average.
- 96% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months was higher than the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the preceding 12 months (01/04/2014 to 31/03/2015) was 100% compared to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and above national averages. 240 survey forms were distributed and 124 were returned. This represented 2% of the practice's patient list.

- 92% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 96% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 96% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 88% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for patient feedback prior to and on the day of our inspection. We received feedback from 53 patients which included CQC comment cards which patients completed prior to the inspection and questionnaires that patients completed on the day of our visit. The majority of feedback was positive. One patient commented on varying experiences with the GPs. Five out of the sixteen patients who we asked about chaperoning were not aware of the chaperone arrangement and three patients said appointments did not run to time.

Areas for improvement

Action the service MUST take to improve

- Ensure that incidents that may affect the health, safety and welfare of people using services are always reported. They must be able to demonstrate that such incidents, whether a significant event or a complaint is recorded, reviewed and thoroughly investigated to prevent further occurrences.
- Ensure the provider always assessed the risks to the health and safety of service users and visitors to the practice. Where risks are identified, ensure measures are put in place to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.
- Ensure the proper and safe management of medicines.
- Ensure systems are in place for assessing the risk of, preventing, detecting and controlling the spread of infections, including those that are health care associated.
- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.
- Ensure patient records are securely maintained.
- Ensure staff receive appropriate support, including appraisal and training relevant to their role.
- Carry out clinical audits including re-audits to ensure improvements have been achieved and that guidance is being followed.
- Ensure an overarching governance framework which supports the delivery of good quality care is put in place.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.

Action the service SHOULD take to improve

- Ensure action is taken to proactively identify carers registered at the practice.

The Friary Surgery

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 second CQC inspector and a CQC pharmacist.

Background to The Friary Surgery

The Friary Surgery, Queens Road, Richmond, North Yorkshire, DL10 4UJ is a semi-rural practice situated in Richmond serving Richmond and the surrounding villages. The registered list size is 5, 850 and approximately 96% are of white British background. The practice is ranked in the eighth least deprived decile, significantly below the national average. The practice age profile is comparable to the England average with the highest age range being 65 years plus. The practice is a dispensing practice and dispenses to approximately 25% of their patients The practice is run by four partners (3.5 wte) 3 female and 1 male and a full time practice manager.

The practice is a teaching practice which takes final year medical students and Foundation Doctors (FY2). This is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/ general practice training.

The practice employs a nurse prescriber, a practice nurse and a health care assistant who works two mornings a week. There is a dispensary manager and a dispenser. A nurse funded by the CCG works at the practice for one day a week as part of a two year nursing project. A pharmacist funded by the CCG has been working at the practice for the last six months primarily carrying out medication reviews. The clinical team is supported by a team of 6 reception staff and one secretary.

The main practice is open between 8am and 6pm Monday to Friday. Extended hours are offered one day a week with two GPs between 6.30pm and 7.30pm. General appointment times for GPs are from 8.30am to 12pm and 2pm until 6pm.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed between 6pm and 6.30pm patients are directed to Primecare and out of hours patients are directed to Harrogate District Foundation Trust (the contracted out-of-hours provider) via the 111 service.

The practice holds a General Medical Services (GMS) contract to provide GP services which is commissioned by NHS England.

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 (HSCA) 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23 June 2016.

During our visit we:

- Spoke with and received feedback from a range of staff including two GP partners, a nurse prescriber, practice nurse, dispensing staff and non-clinical staff.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards and patient questionnaires where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- There was limited evidence to show that significant events and complaints were reviewed and thoroughly investigated to prevent further occurrences and secure improvements. For example, we identified a complaint raised by North Yorkshire County Council in respect of the practices failure to respond appropriately to a safeguarding adult issue. There was no evidence of any investigation, learning or actions from this complaint. Safeguarding adults training had still not been actioned for all staff; despite this complaint and despite this being raised at the CQC inspection in September 2013.
- There was limited evidence to show outcomes of significant event and complaint investigations were always shared with the patient.
- There was evidence to show that significant events were not always reported by staff and acted on accordingly. We noted that significant issues recorded in the dispensary and in the complaints records were not recorded as significant events. For example we noted the dispensary had identified a patient had been receiving the wrong dose of paracetamol for four years but this had not been recorded as a significant event. We also saw a safeguarding complaint that identified a failure to respond appropriately to a safeguarding alert which should have been recorded as a significant event.

Overview of safety systems and processes

The practice had inadequate processes and practices in place to keep patients safe and safeguarded from abuse.

- Arrangements were not in place to always safeguard children and vulnerable adults from abuse. Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The practice had not met regularly with other professionals in respect of child protection and children looked after for six years. We were provided with a report which stated these meetings had now been arranged and were due to commence in July 2016. The majority of staff demonstrated they understood their responsibilities to report and act on safeguarding concerns. GPs and nurses were trained to the appropriate level in child protection or child safeguarding. However, not all staff had completed safeguarding adults training. This had been identified as an area that needed addressing in 2013 and had not been acted on. For example the training matrix showed two GP's a nurse and a health care assistant as well as non-clinical staff had not completed safeguarding adults training.
- A notice in the waiting room advised patients that chaperones were available if required. The nursing team acted as chaperones. Not all the nursing team had received a Disclosure and Barring Service (DBS) check. (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).
- Appropriate arrangements for managing infection control were not in place. We observed the premises to be clean and tidy. There was an infection control lead. We were informed the practice had not been managing infection control well as the nurses did not have time. We saw no evidence that the practice liaised with the local Infection Prevention and Control (IPC) teams to keep up to date with best practice. There was an IPC protocol in place but this was not always followed. Records showed that only two out of seventeen members of staff had received up to date training. We saw evidence that an annual IPC audit was undertaken a few days prior to our inspection. The audit identified some but not all areas that required improvement. We were informed that IPC audits were undertaken annually except for the previous year but there were no records available to support this. Two of the treatment rooms had carpet in them and there were no plans in place for replacing these. The environment had stained floors, chipped woodwork and window sills. There was no record of cleaning of carpets or fabric curtains taking

place. The spillage kits in all the rooms were out of date. New ones were ordered at the point of inspection. We saw that waste segregation and labelling took place appropriately.

The arrangements for managing medicines, emergency drugs and vaccines, in the practice did not always keep patients safe.

- The practice had standard operating procedures (these are written instructions about how to safely dispense medicines) that were readily accessible and covered all aspects of the dispensing process. These were all dated June 2016 with no previous review date evident. We observed medicines being dispensed and saw arrangements were in place to minimise dispensing errors. However, we saw that whilst dispensing errors were logged, there was no record of 'near misses' or significant events for the purpose of review and learning from incident.
- Prescriptions were signed before being dispensed and there was a robust process to ensure that this occurred. There was a named GP responsible for the dispensary and we saw records showing all members of staff involved in the dispensing process had received appropriate training. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.
- There was a protocol for repeat prescribing which was in line with national guidance. This was dated June 2016 and was not followed in practice. For example, there was a process in place for staff to follow when the review date for medication was passed. We checked 18 prescriptions awaiting collection and found that six prescriptions were passed the review date. Three out of the six patients had seen a GP after the medication review date, but there was no evidence that a review had been completed as part of the consultation. Regular medication reviews are necessary to make sure that patients' medicines are up to date, relevant and safe.
- There was a system in place for the management of high risk medicines and we saw examples of how this worked to keep patients safe.
- We saw a system in place for managing national alerts about medicines such as safety issues. Records showed that the alerts were distributed to dispensary staff who implemented the required actions as necessary to protect people from harm.
- Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. There was a pharmacist that worked in the practice that reviewed patients and took part in medicines optimisation initiatives in partnership with their local CCG.
- We checked medicines stored in the treatment rooms and medicines refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were stored at the required temperatures and this was being followed by practice staff. Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- Processes were in place to check medicines were within their expiry date and suitable for use. Medicines were dispensed for patients who did not live near a pharmacy and this was appropriately managed
- We reviewed five personnel files and found that appropriate recruitment checks had not been undertaken. For example, proof of identification, references, and the appropriate checks through the Disclosure and Barring Service (DBS). The practices recruitment policy was dated June 2016. This needed reviewing as it incorrectly referred to Criminal Records Bureau (CRB) checks being obtained. The CRB merged with the Independent Safeguarding Authority (ISA) to become the Disclosure and Barring Service in December 2012.The policy was also unclear as to when and how the practice would obtain a criminal record check for new recruits. We saw evidence that appropriate checks such as professional reference checks and a DBS check had not been carried out on the nurse employed in 2016. We also found that a nurse employed in 2002 and

a health care assistant employed in 2011 did not have a DBS check in place. There were no risk assessments in place for dispensary and non-clinical staff that did not have a DBS check in place.

- Patient paper records (Lloyd George) were stored in the main administration area in filing cabinets that were unlocked during the day. These were accessible from the main corridor via an unlocked door.

Monitoring risks to patients

Risks to patients were not assessed and well managed.

- There was no evidence to show the practice always assessed the risks to the health and safety of patients receiving care or treatment; specifically, risk assessments relating to the health, safety and welfare of people using services were not completed.
- The last health and safety risk assessment was dated 2011. There were no health and safety risk assessments for the environment apart from a COSHH record since this time. A fire risk assessment completed by an external company dated April 2015 highlighted areas of responsibility for the occupiers to address in February 2016. The practice had not actioned or had plans in place to address all of the points identified. For example the practice had failed to ensure that arrangements were in place for the management of fire evacuations, trained staff in fire safety, appointed fire wardens and kept fire doors closed.
- There was no evidence that a suitably trained person was designated as a fire safety lead. These issues have been referred to the fire service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had inadequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Not all staff had received annual basic life support training and CPR. Records showed one GP was last trained in 2014, one in March 2015 and two in June 2015. Two of the practice nurses had last completed training in June 2015 and one of the nurses had not completed any training. Most of the other clinical staffs training was due for annual renewal at the end of June 2016. Non-clinical staff had completed training in 2014 and 2015. The practice confirmed that further training had not been planned for any of the staff.
- The practice did not carry out fire drills and therefore was unable to confirm if they could respond to an evacuation.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. Medicines in GP bags were not in date and unsuitable for use. For example one GP bag had Benzylpenicillin but no sterile water to allow the medicine to be administered.
- The practice had a newly updated business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice kept up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available. Clinical exception reporting was 11.3% which was 3.4% above the CCG average and 2.1% above the England average. Indicators that were 5% above the England average related to Chronic Kidney Disease (CKD) which was 13% above, osteoporosis which was 37% above and cardiovascular disease - primary prevention which was 30% above. We discussed this data with the practice and were satisfied with the data we saw and explanations given. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

- Performance for diabetes related indicators was similar to the national average. The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) was 84% compared to the national average of 88%. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2014 to 31/03/2015) was 81% compared to the national average of 78%.
- Performance for mental health related indicators was higher than the national average.

96% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months were higher than the national average of 84%.The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 100% compared to the national average of 88%.

Data from The NHS Business Services Authority (NHSBSA) electronic Prescribing Analysis and Costs (ePACT) showed the percentage of antibiotic items prescribed that are Cephalosporins or Quinolones (01/07/2014 to 30/06/2015) was significantly higher than the national average at 12% compared to the national average of 5%. More recent data was provided to us which showed the practice had taken action to address this data and had reduced prescribing levels.

The outcome of patients' care and treatment was not always monitored regularly. Clinical audits were not routinely carried out to improve care, treatment and people's outcomes. We asked to see records of at least two clinical audits; we were provided with one which had been carried out by a Foundation Year Two student doctor working at the practice. This related to the prescribing of Diazepam and Zopiclone carried out at the end of December 2014. Whilst this was a two cycle audit there was no specific plan documented as a result of the audit. We were provided with other audits but these were not formal clinical audits. National guidance states "clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence base standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice". The practice did not have any arrangements in place to identify which topics to audit or to link it to current practice or concerns.

Effective staffing

- The practice had an induction programme for all newly appointed staff.
- The practice could not demonstrate how they ensured oversight of role-specific training and updating for relevant staff. Staff received some training but we identified staff that had not completed training in a range of areas that included: safeguarding adults, fire safety awareness, basic life support, infection control and information governance.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of

competence although it took some time to confirm this. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The practice had a policy of informal supervision for GPs and nursing staff. Two of the new starters in the nursing team were competency assessed and appraised. All non-clinical staff including the dispenser and dispensary manager told us they were very well supported and encouraged to develop into new roles and could access training. However, these staff were not appraised. The practice manager was not appraised.

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice had recently established meetings with health visitors and school nurses with the meetings due to commence in July 2016 as these had not been in place for many years.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). Staff had received training relating to the MCA in 2012.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- There was no evidence that consent was monitored through patient records audits.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 86%, which was comparable to the CCG average of 84% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. Childhood immunisation rates for the vaccinations given were slighter higher than the CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 100% and five year olds from 94% to 99%.

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

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the feedback we received from the 53 patients was positive about the service experienced. Patients said they felt the practice offered a good service and mostly staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. Results were in line with local and slightly higher than national averages. For example:

- 94% of patients said the GP was good at listening to them compared to the CCG average of 94% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 92% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and the national average of 95%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 91% compared to the national average of 85%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 93% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to. All but two of the patients said they had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

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

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 92% and the national average of 86%.
- 82% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 82%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. There were no notices in the reception areas informing patients this service was available. The practice information leaflet was available in large print.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. This practice had identified 20 patients as carers, 0.3% of the practice list. Information was available on the practice website to direct carers to the various avenues of support available to them but there was no information in the practice waiting area. We were told the

Requires improvement

Are services caring?

practice was not proactive in reaching out to the wider practice population to encourage carers to register. Some of the clinicians were unclear whether there was a register of carers in place.

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and CCG to secure improvements to services where these were identified. The practice was part of a federation of other practices in the CCG. The practice had benefited from the services through the federation of a pharmacist who was working at the practice. The practice was also working jointly with another local practice in respect as part of the CCG Primary Care Nursing Workforce Project. Evaluation of this project and the impact on patients had not yet been undertaken as the project had only been operating for a short period of time.

- The practice offered a 'Commuter's Clinic' one day a week from 6.30pm to 7.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for those patients identified as needing them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- A phlebotomist service (not funded by the practice) was offered every morning in the building the practice was situated. A phlebotomist service (funded the practice) was available at the practice every Thursday morning.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately including Yellow Fever.
- There were some disabled facilities available. Some areas of the practice were challenging for some population groups. For example, a steep ramp area to some of the consulting rooms and steps to the rear fire exit. Some of the facilities were in need of repair or replacement, for example torn carpets and chairs which posed a health and safety risk.

Access to the service

The practice was open between 8am and 6pm Monday to Friday. Appointments were from 8.30am to12pm every morning and 2pm to 6pm. Extended hours were offered one day a week for two GPs between 6.30pm and 7.30pm. In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them.

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

- 84% of patients were satisfied with the practice's opening hours compared to the national average of 75%.
- 92% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

We noted the next available routine appointment with a GP was two working days from the day of the inspection for a GP and a nurse. People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

The practice had received eleven complaints in the last 12 months. We looked in detail at all of these. Whilst complaints were responded to and the patient given an apology the documentation lacked detail as to how complaints had been investigated. Lessons learned and action taken was not sufficiently detailed to assure lessons had been learnt. Complaints were not monitored over time to enable the practice to look for trends and areas of risk that may be addressed. We also identified complaints that should have been considered as significant events that were not. For example, concerns raised by an external agency in respect of the practices management of a safeguarding alert.

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 staff told us they wanted to deliver good quality care and good outcomes for patients.

- The practice did not have a mission statement. They had aims and objectives within their statement of purpose and staff understood and described the values of the practice.
- There were no detailed or realistic plans to achieve the aims and objectives. The practice did not have a business plan or strategy in place. A basic action plan to address some immediate issues in respect of replacing the practice manager role that was soon to become vacant and some basic infection control issues had been put in place shortly before the inspection.

Governance arrangements

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- The practice did not have an overarching governance framework which supported the delivery of good quality care. The governance arrangements were unclear. There was limited evidence available to demonstrate the monitoring of performance.
- We were told practice policies were mostly introduced or updated in the two weeks prior to our inspection. There was limited evidence of previous reviews or future planned reviews. There was no timetable in place to check policies to ensure they remained relevant. When policies were updated the practice manager shared them with staff. However there were no follow up arrangements in place to check whether staff had read and understood these.
- There was no effective system for identifying, capturing and managing issues and risks which resulted in risks and issues not being identified. Significant issues that threatened the delivery of safe and effective care were not identified or adequately managed..

Leadership and culture

The management at the practice did not demonstrate a clear understanding of their responsibilities under the HSCA 2008. The practice would shortly be losing a key member of the management team and a replacement had not yet been found. During the inspection a GP partner expressed concern about the practices ability to deliver the improvement required.

Staff told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable. However we were also told that some staff were overworked and did not have enough time to carry out specific tasks. We were also told that some staff were not listened to or supported.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Whilst these systems were in place these were not always followed. We were told there was a culture of openness and honesty yet we found incidents when issues were not being reported as significant events. For example, whilst dispensing errors were logged, there was no record of 'near misses' or significant events for the purpose of review and learning from incident.

No formal meetings between staff took place. We were told any issues were discussed at daily coffee breaks. None of these meetings were recorded.

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

There was limited evidence to demonstrate the practice encouraged feedback from patients and staff.

- The practice did not carry out patient surveys. They used the information received from the Friends and Family Test and had made some changes as a result. For example the replacement of more appropriate chairs outside one of the nurses rooms.
- The practice had a virtual PPG with 27 members. The practice consulted the group on some issues but there was minimal engagement. There was limited evidence to show the practice promoted involvement in the PPG.
- The practice did not hold staff meetings. Non-clinical (including the practice manager) and dispensing staff were not appraised. The majority of staff said they felt supported by management. However we were told that some staff, in particular the practice manager and some

Are services well-led?

Inadequate

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

of the nursing staff did not have capacity to fulfil the requirements of their role. We were also told and saw evidence that such issues had been raised with the partners but these were not responded to.

- There was limited evidence of learning from complaints.

Continuous improvement

There was little innovation or service development. There is minimal evidence of learning and reflective practice. The approach to service delivery and improvement was reactive in most instances, for example reacting to CCG initiatives. Improvements were not always initiated by the practice, identified or actioned. Where changes were made the impact was not always monitored

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** **The practice did not always ensure that non-clinical staff including the dispensing and practice manager were appraised.**

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 How the regulation was not being met: Care and treatment was not provided in a safe way for service users. There was no evidence to show the provider always assessed the risks to the health and safety of service users of receiving the care of treatment; specifically, risk assessments relating to the health, safety and welfare of people using services were not completed. There was no evidence to show the provider always ensured it did all that was reasonably practicable to mitigate any such risks; specifically, where risks were identified, the practice did not always introduce measures to reduce or remove the risks within a timescale that reflected the level of risk and impact on people using the service. There was no evidence that all clinical staff were suitably trained in being able to respond to a clinical or non-clinical emergency. There was evidence to show the practice did not have a system in place for assessing the risk of, and preventing, detecting and controlling the spread of infections. There was limited evidence to show that significant events and complaints were reviewed and thoroughly investigated to prevent further occurrences and to make sure improvements were made as a result. There was limited evidence to show outcomes of significant event and complaint investigations were always shared with the person concerned. There was evidence to show that significant events were not always reported by staff and acted on accordingly.

This section is primarily information for the provider

Enforcement actions

There was evidence to show that the arrangements for managing medicines in the practice did not always ensure patients were safe. The practice could not demonstrate the process for repeat prescribing was safe.

Regulation 12(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 How the regulation was not being met: There was evidence to demonstrate there was a failure to have a programme of clinical or non-clinical audit in place which resulted in areas of risk either not being identified or identified and not acted on. There was evidence to demonstrate there was a failure to ensure that systems and processes in respect of Standard Operating Procedures (SOPs) and other procedures had been embedded into practice and that these were understood and followed by staff. There was evidence to demonstrate there was a failure to ensure the systems in place for learning and evaluating the effectiveness of change introduced from all incidents, significant events and complaints was effective. There was limited evidence to show that significant events and complaints were reviewed and thoroughly investigated to prevent further occurrences and to make sure improvements were made as a result. There was evidence to demonstrate there was a failure to ensure the outcomes of significant event and complaint investigations were always shared with the person concerned. There was evidence to demonstrate there was a failure to ensure that significant events were always reported by staff and acted on accordingly. There was evidence to demonstrate there was a failure to act on improvements identified for action. There was evidence to show there was a failure to ensure that a system was in place so that mandatory training was up to date for all staff.

This section is primarily information for the provider

Enforcement actions

There was evidence to show there was a failure to ensure that systems and processes were in place to identify and assess risks to the health, safety and/or welfare of people who use the service.

There was evidence to show there was a failure to securely maintain patient records.

There was evidence to show there was a failure to ensure the provider had listened to, recorded and responded as appropriate to feedback from external bodies.

There was evidence to show there was a failure to obtain patient feedback.

There was evidence to show there was a failure to ensure the provider had obtained the views of external bodies as instructed.

There was evidence to show there was a failure to promote involvement in the Patient Participation Group.

There was evidence to show there was a failure to ensure that effective governance arrangements were in place.

There was evidence to show there was a failure of the partners and practice manager to demonstrate oversight and understanding in respect of the practice.

There was evidence to show there was a failure of the partners and the practice manager to ensure they had an understanding in respect of their responsibilities and requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (The Regulated Activities Regulations 2014).

Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Why the regulation was not being met: The re was evidence to demonstrate the provider did not do all that was reasonably practicable to ensure that information set out in Schedule 3 of the Health and
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Enforcement actions

Social Care Act 2008 (Regulated Activities) Regulations 2014 was confirmed before staff were employed or put in place for those applicable staff employed for a significant amount of time.

Regulation 19(2)