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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Burnham Surgery on 31 March 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 systems and processes were not in place to keep them safe. For example staff acting as chaperones had not received a Disclosure and Barring Service checks and no formal risk assessment had been completed. Risks in relation to health and safety, fire, legionella and infection control had either not been undertaken or managed effectively.
- The practice had a number of policies and procedures to govern activity, but some were outdated and no longer reflected current procedures.
- There was no system in place to ensure staff received, understood and implemented national guidance and guidelines.
- Patients in need of palliative care, at risk of deterioration or developing a long term condition were not being pro-actively identified and those that had been were not receiving effective care and support.
- Staff were not all clear about reporting incidents, near misses and concerns. Those reported were not all recorded in sufficient detail and there was a lack of evidence to reflect that learning had been shared with staff.
- The system in place to manage safeguarding concerns for children and vulnerable was not robust. Some staff had not received training and GPs were unaware how to identify these patients on the computer system.
- There was no robust system in place to ensure staff had completed training appropriate to their role.

Summary of findings

- The practice operated a dispensing service out of the community pharmacy on site. Although dispensing practice was in line with legislation, there was little governance in place to agree procedures and protocols between the practice and the pharmacy and we were not provided with evidence of any medicines audits taking place.
- Prescription use was not being monitored and prescriptions were left in unlocked rooms.

- Data showed patient outcomes were low compared to the locality and nationally and there was no evidence of the practice addressing these areas of poor performance. Although some audits had been carried out, these were incomplete and we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Although staff told us multi-disciplinary meetings took place, we were not provided of sufficient evidence of this. There was a lack of understanding of the importance of patient registers, patients were not being appropriately coded to ensure reviews and referrals could take place.
- Consent was not being sought appropriately; non-clinical staff were gaining consent from patients without providing sufficient information.
  - Patients were positive about their interactions with staff and said they were treated with compassion and dignity. Confidentiality in the reception area could not be ensured, conversations could be overheard and there were no measures in place to minimise this risk.
  - Complaints were dealt with in line with legislation, recorded appropriately and reviewed annually.
  - There was no robust system in place to ensure deceased patients did not receive inappropriate communication from the practice.
- Information about services and how to complain was available and easy to understand.
  - Appointments were available; however we were told by patients we spoke with of difficulties in getting an appointment with a named GP and data showed patients regularly waited more than 15 minutes after their appointment time.
  - The practice had sought feedback from patients and had an active patient participation group; however the practice had not conducted a patient survey since 2014.
  - There was no system in place to ensure the practice reviewed the needs of the local population by engaging with the CCG and other organisations.
  - Staff received annual appraisals. Not all staff were aware of roles and responsibilities within the practice.
  - The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements. There were no plans in place to formalise the practice vision, values or strategy.

The areas where the provider must make improvements are:

- Ensure there is a system in place to enable staff to consistently identify and record significant events, incidents and near misses. Implement a system to ensure this information is shared and that learning is cascaded to relevant staff.
- Take action to identify and address risk at the practice. This includes risks regarding infection prevention and control, fire, health and safety and legionella.
- Ensure that the lead for infection control is appropriately trained.
- Ensure there is a system in place to ensure staff receive training appropriate to their role including safeguarding training, basic life support and infection control.
- Ensure systems are in place to robustly monitor children and vulnerable adults.
- Ensure chaperones are appropriately checked through the Disclosure and Barring Service or a formal risk assessment takes place regarding this issue.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure the health conditions of patients are identified and coded appropriately, including palliative care patients, to enable reviews to be

effectively carried out, thereby improving QOF performance and to ensure that the sharing of information with external organisations such as out of hour's providers is effective.

- Ensure consent is gained appropriately and that all clinical staff know how to record this.
- Carry out clinical audits including re-audits to ensure improvements have been achieved.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.

- Staff should have an adequate understanding of the computer system to enable them to recognise coded patients such as patients at risk.
- Improve the governance arrangements at the practice to ensure there is effective oversight of all issues and that the services provided are regularly assessed and monitored. Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure there are regular multidisciplinary meetings held and documented and that patient records are updated appropriately.

The areas where the provider should make improvement are:

- Improve processes for making appointments with a preferred GP.
- Review the needs of the patient population.
- Ensure patients records are appropriately updated so that staff are aware when a patients is deceased to prevent inappropriate communication with a relative.
- Improve the recall system for checking cervical screening test results and the recall system for patients who have not attended screening appointments.
- Implement suitable agreements between the pharmacy and the practice dispensary service to govern activity.
- Put appropriate measures in place to protect patient confidentiality in the reception area.
- Have a practice vision, values and strategy in place that is shared with staff and ensure that staff are aware of their own and other's roles and responsibilities and how they impact on the performance of the practice.

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 so a rating of inadequate remains 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.

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 understood their responsibilities to raise concerns, and to report incidents and near misses but staff did not always recognise what constituted a significant event. When there were unintended or unexpected safety incidents, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- Risks to patients who used services were not always assessed and the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe, for example with regards to infection control and Legionella
- The system in place to manage safeguarding concerns for children and vulnerable was not robust. GPs did not understand how to flag or recognise patients at risk on the computer system and not all staff had completed appropriate safeguarding training.
- Dispensing services were being carried out in line with legislation but there was a lack of formal governance arrangements in place to demonstrate an effective working relationship between the pharmacy and the practice.
- Prescriptions were not being stored securely and their use was not being monitored.
- Recruitment checks were being carried out for staff prior to employment
- The practice had adequate emergency medicines and equipment in place to deal with medical emergencies.

Are services effective?

Inadequate

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

- Data from the Quality and Outcomes Framework showed the practice performance was below the national average for several aspects of care and treatment.
- Due to a lack of understanding of the computer system, not all staff were coding patient's health condition appropriately; this meant the practice could not ensure patients were being appropriately reviewed.

Summary of findings

- The practice did not have quality improvement processes in place. Audits that had been undertaken were incomplete and did not evidence improvement in the services provided.
- There was minimal engagement with other providers of health and social care. Patient referrals were not always completed in sufficient detail to ensure the best patient outcome for patients.
- Knowledge of and reference to current NICE guidance was inconsistent.
- We were told that multidisciplinary working was taking place but the practice was unable to provide evidence of this.
- Consent was not being appropriately sought or recorded. We were told that non-clinical staff gained patient consent prior to their appointment with a clinician. There was no system in place to ensure patients were informed of the relevant information prior to giving consent.
- The practice had an appraisal system in place and staff had received appraisals.

Are services caring?

Requires improvement

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice comparable to 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 saw that staff treated patients appropriately although confidentiality could not always be assured due to the limited space in the reception area. Telephone conversations could be overheard and steps had not been taken to reduce the risk of confidential conversations being overheard.
- The practice did not have an effective system in place for recording when a patient was deceased to avoid staff making insensitive contact with a family member.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services and improvements must be made.

- The practice could not provide evidence of having reviewed the needs of its local population in the last two years.

Summary of findings

- Patients told us of considerable difficulty in accessing a named GP.
- Patients could get information about how to complain in a format they could understand. These complaints were recorded and reviewed annually.
- Extended hours were provided on Saturdays for patients unable to attend during normal opening hours.
- Phlebotomy services were provided to all adult patients.

Are services well-led?

Inadequate

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

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- There was no clear leadership structure and staff did not all feel supported by management.
- The practice had a number of policies and procedures to govern activity, but many of these were outdated and not in line with current procedures.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- Staff told us they received annual appraisals; however not all staff felt they had clear objectives or responsibilities and were not aware of other staff roles and responsibilities.
- The practice had sought feedback via their patient participation group; however they had not conducted a patient survey since 2014.

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

- The practice had not prioritised safe care of older people. Some staff had not received safeguarding training and systems to manage vulnerable adults were not robust.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were lower than the local and national averages. For example, 69% of patients with COPD had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2014 to 31/03/2015) compared to the national average of 90%.
- The care of older people was not managed in a holistic way.
- The leadership of the practice had little understanding of the needs of older people and were not attempting to improve the service for them**.** Services for older people were therefore reactive, and there was a limited attempt to engage this patient group to improve the service.

People with long term conditions

Inadequate

The practice is inadequate as good for the care of people with long-term conditions. The provider was rated as inadequate for safe, effective and well-led, requires improvement for effective and for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Nursing staff had lead roles in chronic disease management.
- Practice performance for diabetes related indictors was comparable to practices nationally. For example; 77% of patients with diabetes, on the register, had their last blood pressure reading (measured in the preceding 12 months) recorded as 140/80mmHg or less (01/04/2014 to 31/03/2015), this was comparable to the national average of 78%.
- Longer appointments and home visits were available when needed.
- These patients had a named GP; however we were told it was difficult to get an appointment with a named GP.

Summary of findings

- A personalised care plan or structured annual review was not always carried out to check that patient's health and care needs were being met.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for safe, effective and well-led, requires improvement for effective and for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There were no robust system to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk. Safeguarding procedures were not robust and some staff had not received training.
- Immunisation rates were comparable to practice nationally for the standard childhood immunisations.
- Only 51% of patients with asthma, on the register, had an asthma review in the preceding 12 months that included an assessment of asthma control using the three RCP questions (01/04/2014 to 31/03/2015), this was below the national average of 75%.
- Cervical screening rates were comparable to practices nationally.
- Appointments were available outside of school hours and the premises were suitable for families, children and young people.

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

- Online services were available to allow patients to book appointments.
- Extended hours were available on Saturday mornings for patients unable to attend during normal opening hours.
- Health promotion advice was available and patients were signposted to external organisations for support.

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 provider was rated

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

- The practice was not aware of the numbers of their patients living in vulnerable circumstances and we could not be assured that they were receiving appropriate support.
- We were told that longer appointments were available for patients with a learning disability
- The practice told us they had worked with multi-disciplinary teams in the case management of vulnerable people; however we were not provided with adequate evidence of this due to the lack of documentation such as meeting minutes or patient reviews.
- Some staff knew how to recognise signs of abuse in vulnerable adults and children, but they were not all aware of their responsibilities regarding information sharing and documentation of safeguarding concerns.

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

- The practice had not consistently identified patients experiencing poor mental health or those with dementia. We were told these patients were not a priority.
- The practice told us they worked with multi-disciplinary teams in the case management of people experiencing poor mental health, however we were not provided with adequate evidence of this.
- Practice data for mental health related indicators was considerably lower in comparison to other practices nationally. For example; 40% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (01/04/2014 to 31/03/2015), this was far below the national average of 90%.
- The practice did not consistently carry out advance care planning for patients with dementia.
- The practice had not told patients experiencing poor mental health about support groups or voluntary organisations.

Summary of findings

- We were told that non-clinical staff informed the GPs of patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health; however we could not be assured these patients were then followed up.
- Staff had not received training in the Mental Capacity Act 2005; not all clinical staff could demonstrate sound knowledge of this.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with or below local and national averages. 237 survey forms were distributed and 122 were returned. This represented a completion rate of 51%.

- 89% said the last appointment they got was convenient compared to a CCG average of 92% and a national average of 92%.
- 84% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 86% and a national average of 85%.
- 79% described the overall experience of their GP surgery as fairly good or very good compared to a CCG average of 84% and a national average of 85%.
- 70% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to a CCG average of 76% and a national average of 78%.
- 32% usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 64% and a national average of 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received two comment cards which were positive about staff at the practice but negative about the time patients waited for their appointment.

We spoke with ten patients during the inspection. All ten patients said they were happy with the care they received and thought staff were approachable and caring. Patients did tell us it was difficult to get an appointment with a preferred GP and they were aware of staff shortages.

Areas for improvement

Action the service MUST take to improve

- Ensure there is a system in place to enable staff to consistently identify and record significant events, incidents and near misses. Implement a system to ensure this information is shared and that learning is cascaded to relevant staff.
- Take action to identify and address risk at the practice. This includes risks regarding infection prevention and control, fire, health and safety and legionella.
- Ensure that the lead for infection control is appropriately trained.
- Ensure there is a system in place to ensure staff receive training appropriate to their role including safeguarding training, basic life support and infection control.
- Ensure systems are in place to robustly monitor children and vulnerable adults.
- Ensure chaperones are appropriately checked through the Disclosure and Barring Service or a formal risk assessment takes place regarding this issue.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure the health conditions of patients are identified and coded appropriately, including palliative care patients, to enable reviews to be effectively carried out, thereby improving QOF performance and to ensure that the sharing of information with external organisations such as out of hour's providers is effective.
- Ensure consent is gained appropriately and that all clinical staff know how to record this.
- Carry out clinical audits including re-audits to ensure improvements have been achieved.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.

Summary of findings

- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.

- Staff should have an adequate understanding of the computer system to enable them to recognise coded patients such as patients at risk.
- Improve the governance arrangements at the practice to ensure there is effective oversight of all issues and that the services provided are regularly assessed and monitored. Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure there are regular multidisciplinary meetings held and documented and that patient records are updated appropriately.

Action the service SHOULD take to improve

- Improve processes for making appointments with a preferred GP.
- Review the needs of the patient population.
- Ensure patients records are appropriately updated so that staff are aware when a patients is deceased to prevent inappropriate communication with a relative.
- Improve the recall system for checking cervical screening test results and the recall system for patients who have not attended screening appointments.
- Implement suitable agreements between the pharmacy and the practice dispensary service to govern activity.
- Put appropriate measures in place to protect patient confidentiality in the reception area.
- Have a practice vision, values and strategy in place that is shared with staff and ensure that staff are aware of their own and other's roles and responsibilities and how they impact on the performance of the practice.

Burnham 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 practice manager specialist adviser and a pharmacist specialist advisor.

Background to Burnham Surgery

Burnham Surgery is located centrally in the village of Burnham On Crouch, Essex. It is in close proximity to the train station and has parking available. The practice is located in a privately owned purpose built building which, at the time of our inspection, was undergoing some building work.

The practice had a list size of approximately 9,300 patients. The practice had a smaller than average population aged 0 to 44 years old and a larger than average population aged 45 to 85+ years old.

There are three part-time GP partners, one female and two male, and two regular locums. There is a nurse practitioner, three nurses and two healthcare assistants. There is a practice manager and a team of reception and administrative staff.

The practice offers a dispensing service; this is managed by a community pharmacy.

The practice is open between 8am and 6.30pm Monday to Friday and offers extended hours on Saturdays between 9am and 11.30am.

When the surgery is closed a recorded message directs patients to the out of hour's services they can access by calling 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 31 March 2016. During our visit we:

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

Detailed findings

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 no effective 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.
- We spoke to staff who did not have a full understanding of what a significant event was; incidents we witnessed on the day of inspection were not viewed as significant events.
- The practice had not carried out a thorough analysis of the significant events; records were incomplete and had not been shared to encouraging learning or improve patient outcomes.
- There were no minutes of meetings which showed significant events or incidents being discussed.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information and a verbal and written apology. However, as the analysis was not thorough, we were not assured that patients affected by a safety incident had received an accurate account of the issue.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- The practice had a safeguarding policy that was accessible to all staff and outlined who to contact for further guidance if staff had concerns about a patient's welfare. However robust arrangements were not in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. There was a lead GP and nurse for safeguarding, however not all staff were aware of this. The GPs had not attended any safeguarding meetings but provided reports where necessary for other agencies. The GPs and nurses had received safeguarding training but not all GPs had a thorough understanding of safeguarding adults or children from abuse. Healthcare Assistants had not received adequate safeguarding training and non-clinical staff had not completed any formal training but had been provided with some written information to read. Patients at risk were not identified on the practice computer system and GPs we spoke to were not aware that this was possible.
- There was a notice in the waiting area advising patients that chaperones were available if required. There was a chaperone policy available. There were two non-clinical staff who acted as chaperones who were trained for the role but had not received a Disclosure and Barring Service check (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).
- The practice had not maintained appropriate standards of cleanliness and hygiene across the whole practice. We observed the premises to be unclean in places, for example surfaces in the waiting room were dirty and thick with dust. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received training, however the practice policy stated this was an annual requirement and many staff had not received training in the last 12 months. We found no evidence of annual infection control audits being undertaken. The cleaning cupboard was dirty and untidy; it contained dirty cloths and mops. Cleaning schedules were not in place and hygiene systems at the practice were ineffective. Privacy screens in some clinical rooms were not disposable and we could not find any record of them being cleaned or replaced. Clinical waste was kept in appropriate containers however these were left unlocked in an unsecure area. We found sharps bins in clinical rooms which were out of date, for example two were dated 2010 and 2012.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice did not always keep patients safe (including obtaining, prescribing, recording, handling, storing and security). A cylinder of liquid nitrogen was being stored in a cupboard within the staff toilet area. The area was not secured or signed appropriately. The practice told is they carried out medicines audits, with the support of the local CCG medicine management team, to ensure prescribing was in line with best practice guidelines for safe prescribing; however staff could not provide us with evidence of this. We found boxes of waste medicines

being stored in an unsecured area. Prescriptions were logged and stored securely when they arrived at the practice; however there were no systems in place to monitor their use and they were left insecurely in unlocked rooms. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- The practice offered a dispensing service to patients. This was managed and operated by the community pharmacy on site. Dispensing services were carried out in line with legislation, although there was a lack of formal practice policies or protocols in place to govern activity and to protect patient confidentiality. For example, staff employed by the pharmacy were able to access practice patient's records and there was no practice policy in place to govern this activity.
- We reviewed six personnel files and found 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.
- The systems in place to ensure results were received for all samples sent for the cervical screening programme were not failsafe. We were told this was the responsibility of the nursing team and for staff to follow up patients who were referred as a result of abnormal results. We were told by the staff that there was not a failsafe approach to this as it was done on an ad-hoc basis.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were inadequate procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy, however this was out of date, it was dated 2004 and did not reflect the current premises, in addition the health and safety risk assessment no longer reflected the premises. The practice had a fire risk assessment dated 2012 but this no longer reflected the current premises; the practice had carried out regular fire drills. The practice had legionella risk assessment dated 2012 which deemed the premises to be high risk yet there was no evidence of any actions having been taken to address this risk. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). There was no evidence of risk assessments to address infection control or the control of substances hazardous to health. Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were told there was a shortage of clinical staff at present and that locum and agency GPs were being used.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All clinical staff received annual basic life support training and there were emergency medicines available in the treatment room. Non-clinical staff did not routinely receive basic life support.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff and all staff knew of their location. All the medicines we checked were in date.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice did not consistently assess needs and deliver care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice did not have systems in place to ensure all clinical staff were up to date. Staff had access to guidelines from NICE and updated themselves on an individual basis but there was no system in place to ensure staff were following guidelines or were aware of safety alerts.

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 81% of the total number of points available, with 8% exception reporting. (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). This practice was an outlier for several QOF (or other national) clinical targets. Data from 2014/2015 showed;

- Performance for diabetes related indicators was comparable to the national average. For example; 88% of patients on the diabetic register, had a record of a foot examination with risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) which was the same as the national average.
- 75% of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90 mmHG or less (01/04/2014 to 31/03/2105), this was below the national average of 84%
- Performance for mental health related indicators was worse than the national average. For example, 41% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their record, in the preceding 12 months (01/04/2014 to 31/03/2015); this was below the national average of 88%.
- 51% of patients with asthma, on the register, had an asthma review in the previous 12 months that included as assessment of asthma control using the 3 RCP questions (01/04/2014 to 31/03/2015); this was below the national average of 75%.

We were told by the GPs that this poor QOF data was probably due to staff shortages, they were also unaware of some areas of high exception reporting; however we were told that anyone being treated in secondary care was immediately exception reported. There were no plans in place to address these areas of poor performance.

Clinical audits had not demonstrated quality improvement.

- There had been five clinical audits completed in the last two years, none of these were completed audits where the improvements made were implemented and monitored.
- The practice did not have any evidence of participation in local audits, national benchmarking, accreditation, peer review and research.
- There were no other systems in place for quality improvement at the practice and no evidence that reflected the practice were aware of their performance issues and taking appropriate action to improve.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment in the areas they were qualified in; however, due to staff shortages there were not always staff available to deliver certain aspects of treatment.

- The practice had a basic induction programme for all newly appointed staff to discuss clerical issues. Topics such as safeguarding, infection prevention and control, fire safety, health and safety or confidentiality were included in the staff handbook which was provided to all staff.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff as there was no robust system in place to ensure all staff received training in line with practice policies. For example; Non-clinical staff had not received basic life support training within the last three years and not all staff had received infection control training in line with the practice policy. Staff who were able to administer vaccinations and take samples for the cervical screening programme had received specific training which had

Inadequate

Are services effective?

(for example, treatment is effective)

included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and peer reviews.

- At the time of our inspection, due to a shortage in clinical staff, some long term condition reviews were not being carried out. There had been periods of time when immunisations were unavailable due to staff shortages.
- The learning needs of staff were identified through appraisals. Staff had access to training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, supervision and facilitation for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Most staff received training that included: manual handling, fire procedures and information governance awareness. Staff had access to and made use of e-learning training modules.

Coordinating patient care and information sharing

Most information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system; however not all clinical staff knew how to access this information.

- This included care and risk assessments, care plans, medical records and investigation and test results; however we could not be assured that all patient records and care plans were up to date.
- Information such as NHS patient information leaflets was available.
- The practice did not always share relevant information with other services in a timely way, for example when referring patients to other services. We saw evidence of incomplete referrals resulting in patients being referred to the wrong location for treatment.

There was a lack of available evidence to demonstrate if or when staff worked with other health and social care services to understand and meet the range and complexity of patients' needs or 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. We were told that multi-disciplinary team meetings took place on a monthly basis; however there was no evidence of these meetings taking place. We were told there were only five palliative care patients on the practice list, only one of these patients had an end of life care plan, this record did not include a do not resuscitate order despite the GP telling us there was one. We later found that the decision to add a patient to the palliative care list was taken by administrative staff not clinical staff.

Consent to care and treatment

Staff had not always sought patients' consent to care and treatment in line with legislation and guidance.

- Not all staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had not received training on the Mental Capacity Act 2005.
- We were told that non-clinical staff would seek consent from patients prior to their consultation. There was no evidence that a patient could be made fully aware of the treatment they were consenting to at this stage.
- 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 in the notes of patient records but we found they were very brief and contained limited detail.
- The process for seeking consent was not monitored through records audits.

Supporting patients to live healthier lives

The practice did not always identify patients who may be in need of extra support.

- Patients in the last 12 months of their lives, and those at risk of developing a long-term condition were not always being identified or offered additional support.
- Due to staff shortages, there was a lack of staff qualified to carry out some long-term condition reviews, such as diabetes and COPD.
- Patients requiring advice on their diet, smoking and alcohol cessation were signposted to external services.
- The nursing team identified carers at patient health checks; these patients were offered information on support available and were also offered annual flu vaccinations.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 79%, which was slightly lower than the national average of 82%. The nursing team tried to offer telephone reminders for patients who did not attend for their cervical screening test; however we were told this recall system was not failsafe due to the current pressures staff were under.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example:

- The percentage of childhood PCV booster vaccinations given to under five year olds was 96% compared to the CCG percentage of 95%.
- The percentage of childhood Men C vaccinations given to under one year olds was 99% compared to the CCG percentage of 99%.

At the time of our inspection there was only one nurse trained to give immunisations, when this member of staff was absent, immunisations could not take place.

Patients had access to appropriate health assessments and checks; this was carried out and monitored by the nursing team. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made by the nursing team 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 polite and helpful to patients.

Screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Some consulting rooms had an internal examination room with a door to provide privacy.

- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The reception area was very busy and there was no system in place to protect patient's privacy, phone calls could also be overheard.

The two patient Care Quality Commission comment cards we received were positive about the service experienced, with the exception of waiting times for appointments. Patients said they felt and staff were helpful and caring.

We spoke with seven members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey published In January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice performance was comparable to the CCG and nationally for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 89% said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 87% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the 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 92% and the national average of 91%.
- 88% said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 86% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 85% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language.

There was insufficient evidence to demonstrate how older patients, patients with long term conditions, vulnerable patients or poor mental health were being cared for. Patients requiring palliative care were not actively being identified. QOF data did not demonstrate that patient's with poor mental health were being cared for appropriately. There was no robust system in place to ensure patients with long term conditions were being reviewed and cared for. Due to a lack of multidisciplinary meetings or sufficient safeguarding training, we could not be assured that vulnerable adults were being cared for.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Requires improvement

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 2% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them on a notice board in the waiting area.

Staff told us that if families had suffered bereavement, their GP may call them if they knew them; however it was apparent from witnessed events there was not a robust system in place to ensure deceased patients were not contacted in writing by the practice.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had tried to review the needs of its local population in the past and had limited engagement with the NHS England Area Team and Clinical Commissioning Group (CCG); however due to current pressures and difficulties within the practice, this current engagement was minimal and there was no evidence provided of any reviews in the last year.

- The practice offered extended hours on a Saturday morning between 9am and 11.30am for pre-booked appointments.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- The practice cared for patients within one care home in the locality, the nurse manager visited weekly to review these patients.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS.
- There were facilities for the disabled, including toilet facilities, although there was no emergency pull cord within this area. There was no hearing loop available. Translation services were available.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available at various times through these opening times dependent upon which GPs were available. Extended surgery hours were offered between 9am and 11.30am every Saturday. In addition to pre-bookable appointments that could be booked up to eight weeks in advance, urgent and walk-in 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 mainly below local and national averages.

- 65% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 31% of patients felt they don't normally have to wait too long to be seen compared to the CCG average of 58% and the national average of 58%.
- 65% of patients were satisfied with the surgery's opening times compared to the CCG average of 71% and the national average of 75%.

However, some results were more positive:

- 75% of patients said they could get through easily to the surgery by phone compared to the CCG average of 64% and the national average of 73%.
- 73% of patients said they always or almost always see or speak to the GP they prefer compared to the CCG average of 61% and the national average of 59%.

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

The practice were aware of this data but were not actively addressing the areas for improvement.

Listening and learning from concerns and complaints

The practice had an effective 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 in the patient leaflet and on the practice website.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and there was openness and transparency when dealing with the complaint. Lessons were learnt from concerns and complaints and these were shared at an annual complaints review.

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 not have a clear vision or strategy to deliver high quality care and promote good outcomes for patients.

- Despite being aware of the issues facing the practice they did not have a robust strategy or supporting business plan in place to ensure a constructive approach to overcoming the problems experienced by the practice.

Governance arrangements

The practice did not have an overarching governance framework to support the delivery of the strategy and good quality care.

- There was no clear staffing structure, staff were aware of their own roles and responsibilities but not of other staff's roles or responsibilities. We were told by some staff that the practice was disjointed and there was an apparent lack of understanding of lead roles within the practice. We were made aware of staff having to carry out roles without appropriate training or experience. It was apparent that some members of staff were solely responsible for certain aspects of work and when absent there was no one else trained to undertake the work.
- Practice specific policies were available to all staff, however some were not being implemented and some were outdated and did not align with the current practice.
- A comprehensive understanding of the performance of the practice was not being maintained, areas of poor QOF data or high exception reporting was not understood or being addressed.
- A programme of continuous clinical and internal audit was not being used to monitor quality or to make improvements.
- There were no robust arrangements for identifying, recording and managing risks, issues or implementing mitigating actions. Risk assessments were missing or out of date and actions had not been taken to address any issues raised.
- The dispensary was managed by the pharmacist who also managed the 100 hour pharmacy on site. This was a separate business however there were no policies or formal agreements between the practice and the pharmacy to govern activity. There was no confidentiality agreement for pharmacy staff to access practice patient records.

Leadership and culture

The partners in the practice did not have the capacity or capability to run the practice or ensure high quality, safe care. The partners were visible in the practice and staff told us they were approachable but felt there was a lack of integration between the partners and other staff.

Due to the number of issues found on the day of the inspection it was apparent that the leadership was ineffective.

The provider was aware of and complied with the basic requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. However we found that they were not being analysed effectively and learning shared with staff.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology but due to the lack of a thorough investigation we were not assured that patients affected by the safety incident received an accurate account of the issue.

There was no clear leadership structure in place and staff did not always feel supported by management.

- Staff told us the practice held practice meetings; however we were not provided any evidence of meeting minutes between July 2015 and March 2016.
- Staff told us there was tension within the practice due to staff shortages. Not all staff felt supported by the partners within the practice and we were told that this pressure may have been the cause of many staff leaving the practice.
- Staff were unsure of the plans for the future or how the practice would overcome the current difficulties.

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

The practice encouraged and valued feedback from patients, the public and staff. It sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Inadequate

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and complaints received. There was an active PPG which met regularly and submitted proposals for improvements to the practice management team. For example, the group had given suggestions on how to reduce the number of appointments missed by patients; they had provided newspaper articles for the local press and held talks with other local organisations in the area.
- The practice had not carried out a patient survey since 2014; staff were aware of the national GP survey but were not actively addressing issues raised within it.
- The practice had gathered feedback from staff through annual appraisals, we were also told of staff meetings, however there was a lack of documentation to evidence this. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues; however they found it difficult to discuss issues with management due to the current pressures they were under.
- Staff told us they did not all feel involved or engaged to improve how the practice was run as they were all too busy trying to cope with the daily pressures of seeing 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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. Staff acting as chaperones had not received Disclosure and Barring Service checks.** **This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not do all that was reasonably practicable to ensure consent was being provided in line with legislation.** **This was in breach of regulation 11 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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not do all that was reasonably practicable to assess, monitor, manage person centred care. There was no evidence of multidisciplinary meetings and palliative patients were not being identified. There was no robust referral system in place to ensure the continuity of care. Staff were not able to identify deceased patients to prevent inappropriate communication with families. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. Risk assessments were either not carried out or not actioned. Prescriptions were not stored securely and their use was not monitored. Infection control measures were inadequate and there was no system in place to monitor this. Liquid nitrogen was not stored safely. There was no adequate system in place to safeguard patients from abuse, staff did not know how to recognise these patients on the computer system and some staff were not adequately trained. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not do all that was reasonably practicable to ensure an overarching governance system was in place. Policies and procedures were outdated and ineffective. There was no evidence of audits or feedback being used to drive improvements. There was a lack of leadership within the practice. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.