St Johns Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Good
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 St Johns Medical Centre on 29 September 2015.

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

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, safeguarding, infection control, staff training, monitoring of palliative care patients.
- A business continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice.
- There was insufficient assurance to demonstrate people received effective care and treatment.
- 90% of patients who responded to the July 2015 national patient survey said they would recommend the surgery to others. 95% of respondents said they had confidence and trust in the last GP they saw or spoke to. 98% who responded said they had confidence and trust in the last nurse they saw or spoke to.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Comment cards were positive about the standard of care received. They identified that staff were caring, polite, respectful and professional.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments and that it was often very difficult to get through to the practice when phoning to make an appointment.

Summary of findings

- The practice had limited formal governance arrangements.

The areas where the provider must make improvements are:

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for recording, analysing and acting upon significant events, infection control, palliative care, staff training and review of pathology results.
- Implement robust governance arrangements to ensure appropriate systems are in place for assessing and monitoring the quality of services provided. This should include audits of practice are undertaken, including completed clinical audit cycles.
- Have a system in place to ensure that patients are safeguarded from abuse and improper treatment
- Embed a process to ensure emergency equipment and vaccine refrigerators are checked as per the practice policy.
- Have a system in place for the summarising of patient notes. Clear the backlog of paper records for new patients.
- Put a system in place to ensure prescriptions are dealt with in line with national guidance
- Carry out reviews for patients with a learning disability.
- Put a robust system in place for the recall of patients with long term conditions and vaccination programmes.
- Ensure CQC registration is up to date and correct in regard to registration of the practice

The areas where the provider should make improvement are:

- Carry out a risk assessment for legionella and put a policy in place to provide guidance for staff.
- Ensure that staff who undertake the role of a chaperone have a Disclosure and Barring (DBS) check.
- Improve the system for the identification of carers
  - Embed a process to do yearly checks for Nursing and Midwifery (NMC) or General Medical Council (GMC) status.
  - Ensure all staff have a yearly appraisals.
- Ensure learning from complaints is disseminated to all staff

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. Special measures will give people who use the practice the reassurance that the care they get should improve.

In addition to this I have issued a warning notice to the practice in regard to Regulation 13 Safeguarding service users from abuse and improper treatment which the practice will have had to comply with by 17 December 2015.

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.

There was insufficient information to enable us to understand and be assured about safety. The system for the reporting, investigation and dissemination of learning from significant events was disjointed and not robust so safety was not always improved. Patients were at risk of harm because systems and processes were either not in place or not well implemented in a way to keep them safe. For example, safeguarding, medicine management, dealing with emergencies, infection control.

Are services effective?

Inadequate

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

Data showed patient outcomes were at or below average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. There was evidence of appraisals for some staff groups but the nursing team had not had an appraisal since 2013. There was little support for any additional training that may be required. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example, urgent access appointments were available. Home visits were available for older patients or patients who would benefit from these. Extended hours were available on Tuesday evening and a Saturday morning.

Results from the July 2015 national patient survey showed that patient's satisfaction with how they could access care and treatment was above average in comparison to local and national averages and people we spoke to on the day were able to get appointments when they needed them. Longer appointments were also available for older patients, those experiencing poor mental health, patients with substance misuse and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a number of local care homes as required and to those patients who needed one.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. However themes and trends had not been identified and learning from complaints was not always shared with staff.

Are services well-led?

Inadequate

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

There was a documented leadership structure and most staff felt supported by management but at times they weren't sure who to approach with issues. The practice did not have a clear or consistent system in place for reporting, recording and monitoring significant events, incidents and accidents. There was not a structured or robust approach for dealing with safeguarding. There was not a robust system in place to ensure that the patient group directives (PGD's) were signed by a GP and all relevant members of the nursing team.

The practice had not proactively sought feedback from staff or patients. The virtual patient participation group (v PPG) was active. All staff had received inductions but not all staff had received regular performance reviews or attended staff meetings and 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 provider was rated as good for being caring and responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Care and treatment of older people did not always reflect current evidence-based practice, as some older people did not have a care plan where necessary. The practice had appointed a practice care-co-ordinator in August 2015 who would be completing care plans for patients who needed them. All patients over the age of 75 had a named GP. 88% of patients over 75 had received a medical review. Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions.

The provider was rated as good for being caring and responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. 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, Longer appointments and home visits were available when needed. Not all these patients had received a structured annual review to check that their health and medication needs were being met. 96% of patient with diabetes had been reviewed. 94% of patients with COPD had received an annual review. 86% of patients with Asthma had received an annual review. Only 36 % of patients on the palliative care register had been reviewed.

The practice ran an in house musculoskeletal service.

For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people

Summary of findings

The provider was rated as good for being caring and responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice did not have robust systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, looked after children

Childhood immunisation rates were relatively high for the under two age group but below CCG/national average for five year olds'. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours. The practice offered chlamydia screening for patients aged 15-24. 3% had attended for screening.

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 good for being caring and responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, including 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. Only 44% of patients aged 40-74 had received a NHS Healthcheck.

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 good for being caring and responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

The practice had a register for patients with a learning disability. None had received an annual review. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. For example, it had an in house substance misuse service in partnership with the Drug and Alcohol Recovery Team (DART) four days a week. Two GP's held the substance misuse certificate Part Two.

It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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 good for being caring and responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. The concerns which led to these ratings apply to everyone using the practice, including this population group.

69% of people experiencing serious mental health problems or dementia had an agreed care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. For example, the practice offered an in house counselling service and had a psychiatrist who attended the practice and ran a weekly clinic. The practice co-ordinator attended the admission avoidance meetings and supported the Grantham Volunteer dementia group.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. For example, the crisis team and community elderly mental health team. Patients experiencing poor mental health could be booked in with an in house therapist within a week or offered the support of the in-house mental health facilitator.

Summary of findings

What people who use the service say

The national patient survey results published in July 2015 showed the practice was performing above local and national averages in most areas. There was a response rate of 39%.

- 86% find it easy to get through to this surgery by phone compared with a CCG average of 72% and a national average of 73%.
- 92% find the receptionists at this surgery helpful compared with a CCG average of 88% and a national average of 87%.
- 75% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 58% and a national average of 60%.
- 86% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.
- 95% say the last appointment they got was convenient compared with a CCG average of 94% and a national average of 92%.
- 78% describe their experience of making an appointment as good compared with a CCG average of 73% and a national average of 73%.
- 79% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 68% and a national average of 65%.
- 75% feel they don't normally have to wait too long to be seen compared with a CCG average of 62% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards. 35 comments cards were positive about the standard of care received. They identified that staff were caring, polite, respectful and professional.

Areas for improvement

Action the service MUST take to improve

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for recording, analysing and acting upon significant events, infection control, palliative care, staff training and review of pathology results.
- Implement robust governance arrangements to ensure appropriate systems are in place for assessing and monitoring the quality of services provided. This should include audits of practice are undertaken, including completed clinical audit cycles.
- Have a system in place to ensure that patients are safeguarded from abuse and improper treatment
- Embed a process to ensure emergency equipment and vaccine refrigerators are checked as per the practice policy.
- Have a system in place for the summarising of patient notes. Clear the backlog of paper records for new patients.
- Put a system in place to ensure prescriptions are dealt with in line with national guidance
- Carry out reviews for patients with a learning disability.
- Put a robust system in place for the recall of patients with long term conditions and vaccination programmes.
- Ensure CQC registration is up to date and correct in regard to registration of the practice

Action the service SHOULD take to improve

- Carry out a risk assessment for legionella and put a policy in place to provide guidance for staff.
- Ensure that staff who undertake the role of a chaperone have a Disclosure and Barring (DBS) checks.

Summary of findings

- Improve the system for the identification of carer.
- Embed a process to do yearly checks for Nursing and Midwifery (NMC) or General Medical Council (GMC) status.
- Ensure all staff have a yearly appraisals.
- Ensure learning from complaints is disseminated to all staff

St Johns Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a CQC Inspector and a GP practice manager specialist advisor.

Background to St Johns Medical Centre

St Johns Medical Centre provides primary medical services to approximately 15,500 patients.

At the time of our inspection the practice employed five GP partners (three male, two female), three salaried GPs , one practice manager, one assistant practice manager, two advanced nurse practitioners, one diabetic nurse specialist, one practice care co-ordinator, four practice nurses, two health care assistants, one reception manager and reception and administration staff.

The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice has one location registered with the Care Quality Commission (CQC) which is St Johns Medical Centre, 62 London Road, Grantham, Lincs. NG31 6HR

St Johns Medical Centre is open from 8.00am to 6pm Monday to Friday. Appointments with a GP were available from 8.50am to 5.30pm Monday to Friday. The practice had extended hours from 6.30pm to 8pm on a Tuesday and Saturday 9am to 11am. These appointments were particularly useful to patients with work commitments. Urgent on the day appointments were also available with a nurse practitioner.

Appointments could be booked on line for GPs and could be booked up to four weeks in advance.

The practice is located within the area covered by NHS SouthWest Lincolnshire Clinical Commissioning Group (SWLCCG). The CCG is responsible for commissioning services from the practice. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

NHS South West Lincolnshire Clinical Commissioning Group (SWLCCG) is responsible for improving the health of and the commissioning of health services for 128,000 people registered with 19 GP member practices and the surrounding villages.

The practice had a website which we found had an easy layout for patients to use. It enabled patients to find out a wealth of information about the healthcare services provided by the practice. Information on the website could be translated by changing the language options. This enabled patients from eastern Europe to read the information provided by the practice.

We inspected the following location where regulated activities are provided: - St Johns Medical Centre, 62 London Road, Grantham, Lincs. NG31 6HR

St John's Medical Centre had opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided by Lincolnshire Community Health Services NHS Trust.

We spoke with the management team in regard to the practice's registration certificate. The practice were

registered with the Care Quality Commission but the certificate had not been updated since two GP partners had left the practice. We spoke with the management team who told us that they were in contact with CQC in order to progress a new registration certificate.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed information from SouthWest Lincolnshire Clinical Commissioning Group (SWLCCG), NHS England (NHSE), Public Health England (PHE), Healthwatch and NHS Choices.

We carried out an announced inspection on 29 September 2015.

We asked the practice to put out a box and comment cards in reception to enable patients and members of the public could share their views and experiences.

During the inspection we spoke with four patients. We reviewed 37 completed comment cards where patients had shared their views and experiences of the service.

On the day of the inspection we spoke with GP partners, practice manager, assistant practice manager, one advanced nurse practitioner, two nurses, primary care co-ordinator, one health care assistant, and members of the reception and administration team.

We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not have a robust system in place to ensure that incidents were recorded, investigated and reviewed in a consistent manner. It was not apparent that all staff were aware of their responsibilities to raise concerns, or knew how to report incidents and near misses. We saw examples of three incidents that had occurred and been discussed in a practice meeting but had not been reported as a significant event. Therefore we could not be assured that the practice could evidence a safe track record over the long term.

Learning and improvement from safety incidents

We reviewed records of six significant events that had occurred during the last 12 months and saw two examples where the event had been investigated, learning had been identified and actions had taken place. For example, patient notes not filed in order, staff went into practice at a weekend to rectify this problem.

We looked at minutes of a practice meeting which took place on 23 June 2015 and found three incidents discussed but incident forms had not been completed and no record of any investigation had been documented. Therefore the practice had a system in place but evidence demonstrated that it was not consistent.

During our inspection, we requested details of annual reviews of significant events. We were told that these had not been carried out and that there had been no exercise undertaken to identify any themes or trends.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. We saw evidence that NICE guidance had been discussed at a clinical meeting. National patient safety alerts were disseminated by the practice manager. We were told that actions from any safety alert were undertaken by the practice prescribing lead and this included a search of patient records to ascertain if any patients needed a review of their medicines. We did not see any evidence that safety alerts were discussed at any meetings held within the practice.

Overview of safety systems and processes

During our inspection we found evidence that there were inadequate systems or processes in place to safeguard service users from abuse and improper treatment.

- The practice had an appointed dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary training to enable them to fulfil these roles. Most staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.
- The practice did not have a robust system in place to monitor children on the at risk register or identify looked after children. We found that not all children had alerts on their patient records.
- We asked the Lead GP for safeguarding about the process for the discussion of vulnerable adults and children. We were told the practice did not have a system in place and we found that no multi-disciplinary safeguarding meetings took place.
- Staff, including receptionists who undertook chaperone duties had received detailed training from one of the GP partners and understood their responsibilities. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Not all staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Neither was there a risk assessment in place to address this.
- We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We checked the recording logs for three medicine refrigerators within the practice. There were omissions in the records of vaccine refrigerator temperature checks in treatment room one, reception back office and a practice nurse room of the practice. Refrigerator temperature checks were not carried out on a daily basis to ensure that medication was stored at the appropriate temperature. Therefore the practice could not demonstrate the integrity and quality of the medicines were not compromised.
- The practice did not have a clear cold chain policy to provide guidance to staff or which detailed the process to ensure that medicines were kept at a regular

temperature and described the action to take in the event of a potential failure. However, processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

- All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription pads were kept securely but we could not be assured that the practice had a system in place that if prescriptions were lost or stolen that they could promptly be identified and investigated.
- Blue prescriptions, used for substance misuse, were not kept securely during the practice opening hours. We found that they were not kept locked away and there was no system in place if prescriptions were stolen or lost so that they could promptly be identified and investigated.
- The practice did not have a system in place for the collection of prescriptions for Controlled Drugs (CD).They did not obtain a signature when these prescriptions were collected or record by whom.
- There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.
- The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines.There was not a robust system in place to ensure that the PGD's were signed by a GP and all relevant members of the nursing team. Patient group directions (PGDs) are specific written instructions for the supply or administration of a licensed named medicine including vaccines to specific groups of patients who may not be individually identified before presenting for treatment.
- Three members of the nursing staff was qualified as independent prescribers. We were told that they received regular informal supervision and support in their role. However due to lack of time training updates in the specific clinical areas of expertise for which they prescribed did not always take place.
- The practice did not have effective systems to ensure patients and staff were protected from the risk of infection. One of the practice nurses was the lead for infection control. The infection control lead had not attended any training to enable them to provide advice on the practice infection control policy and carry out staff training. We spoke with the infection control lead who told us she would be attending her first infection control update meetings the next day. Staff had received induction training about infection control specific to their role and most staff had received annual updates.
- We observed the premises to be generally clean and tidy. The practice employed an external cleaning company. We saw there was a cleaning schedule for the premises which had been provided by the cleaning company. However this was not detailed enough for specific areas of the practice, for example treatment rooms. The records seen were not robust enough to provide assurance that individual rooms or areas had been cleaned. There were no formal records of any spot checks having taken place. We spoke with the management team who told us they would implement this.
- The practice had carried out an infection control audit of the rooms used by the practice nurses on 26 September 2015. Prior to this there was no evidence of any infection control audits having been carried out in order to identify any improvements required. The current audit had identified a number of areas which the practice needed to address. They had not had the opportunity to do this at the time of our inspection as the audit had been carried out three days before our visit. The practice had not completed any further audits of the rest of the premises.
- An infection control policy and supporting procedures were available for staff to refer to. This had been due to be reviewed in January 2014. The policy gave guidance on different areas such as personal protective equipment.
- The practice had arrangements in place for the safe disposal of clinical waste and sharps such as needles and blades. We saw evidence that their disposal was arranged by a suitable external company.
- We were shown a legionella testing certificate dated April 2015. However the practice did not an on-going

system, risk assessment or policy in place for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).

- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

Staffing and recruitment

- The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification and references, not all staff had received a check through the Disclosure and Barring Service. There was no risk assessment in place to evaluate this.
- Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. They told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

- The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included some checks of the building, the environment, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.
- The practice had employed a health and safety consultancy firm to carry out a health and safety review in August 2015 and we saw that risks had been identified. An action log had been practice intended to have addressed the issue and who was responsible. The deputy practice manager told us that health and safety risks were discussed at practice meetings.

Arrangements to deal with emergencies and major incidents

- There was not a robust system in place for checking emergency equipment and medicines including the doctors' bags. There were omissions in the records for the checking of emergency equipment and medicines. The checking of emergency equipment and medicines protocol stated the checks would take place on a daily basis by a designated nurse. The checking of a doctor's bag was not included on this protocol.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. Most of the medicines we checked were in date and fit for use. However when we checked the contents of one doctor's bag. We found items which were past there expiry date, for example, diclofenac injection and water for injection.
- Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). We checked that the pads for the automated external defibrillator were within their expiry date. The practice had adult defibrillator pads but no child defibrillator pads available. When we asked members of staff, they all knew the location of this equipment.
- A business continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk
- The practice had carried out a fire risk assessment in April 2015 that included actions required to maintain fire safety. We saw that these actions had either been completed or were in progress.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment 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 had systems in place to ensure all clinical staff was kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

We saw minutes of clinical meetings held in March and September 2015 where NICE guidance was discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was not routinely collected and monitored and information used to improve care.

We found on the day of the inspection that the practice did not have a robust or clear system for the recall of patients. We were told that this was done on an opportunistic and ad-hoc basis. Staff we spoke with were unsure whose role it was for what system the practice had in place to recall patients.

The practice ran an in-house musculoskeletal service. The aim was to treat conditions or injuries that affect muscles, tendons, ligaments, bones, joints and associated tissues. Patients with musculoskeletal conditions need a wide range of support and treatment from simple advice to more specialised medical and surgical treatments. St Johns Medical Centre saw patients in a double appointment where a full assessment was carried out. A plan of care is then put in place for each patient with regular monitoring by the lead GP. A referral could then be arranged as required to a range of health professionals including physiotherapists and Orthopaedic or Rheumatology Consultants.

The practice did not have a robust system in place for carrying out full cycle clinical audits. Audits we were shown were a review of a process, for example, Hepatitis C but it lacked detail, plan of action, date to be completed by or that it had been discussed in the practice. There was no system or process in place to identify areas for quality improvement in patient care and outcomes against defined criteria with subsequent evidence of implementation of changes to facilitate this and regular review of these outcomes.

On the day of the inspection we did not find any evidence to demonstrate that the practice had systems and processes in place to monitor the quality of the service and to ensure they were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was not performing in line with national standards in a number of areas. We were told by the practice that they discussed QOF informally almost daily but the practice could not demonstrate this as no formal minutes had been taken. QOF results from 2013/14 were 87.7% of the total number of points available, with 5.2% exception reporting. This was 9.2% below the CCG average and 5.8% below the national average.

The practice was an outlier for some of the QOF clinical targets.

For example:

- The performance for diabetes related indicators was 90.6% which was 2.8% below the CCG average and 0.5% below the national average.
- The performance for asthma related indicators was 69% which was 29.2% below the CCG average and 28.2% below the national average
- The performance for patients with hypertension was 96.9% which was 2.2% below the CCG average and 8.5% below the national average.
- The performance for patients with COPD was 71% which was 25.4% below the CCG average and 24.2% below the national average.
- The dementia diagnosis rate was 60.4% which was 33.7 % below the CCG average and 33% below the national average.

The practice had identified diabetes management and dementia as two areas that required improvement from

Inadequate

Are services effective?

(for example, treatment is effective)

2013/14 figures. They had appointed a diabetic nurse specialist and had recently had a new member of staff join the practice to continue this role. The practice had also recently employed a practice care co-ordinator whose role included the completion of care plans for patients in nursing homes and those who have dementia. In addition one of the health care assistants has been trained to use the CANTAB tool which gives a quick and accurate assessment of a patient's memory. The results will then be reviewed by their named GP.

After the inspection we looked at the QOF data for 2014/15 which demonstrated that the practice had improved it overall QOF total to 95% of the total number of points available with 9% exception reporting. This was 1.1% below CCG average and 1.5% above national average.

- The performance for diabetes related indicators was 98.8% which was 7.2% above the CCG average and 9.6% above the national average.
- The performance for asthma related indicators was 100% which was 2.2% above the CCG average and 2.6% above the national average
- The performance for patients with hypertension was 100% which was 0.6 % above the CCG average and 2.2% above the national average.
- The performance for patients with COPD was 94.3% which was 2.5% below the CCG average and 1.7 % below the national average.
- The dementia diagnosis rate was 92.3% which was 3.7 % below the CCG average and 2.2% below the national average.

The practice's prescribing rates were similar to national figures. For example, average daily quantity of Hypnotics prescribed was 0.31% compared to the national average of 0.28%. Number of Ibuprofen and Naproxen Items prescribed as a percentage of all Non-Steroidal Anti-Inflammatory drugs Items was 73.15% compared to the national average of 75.13%.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. Up to June 2015 antibiotic prescribing for the practice was 0.93 which was lower than the CCG rate of 1.12. The prescribing of cephalosporin's and quinolone rates for the practice was 7.71% was lower that the CCG rate of 11.81%.

The practice did not have a robust or adequate system in place for palliative care monitoring and review. The practice had 16 patients on a palliative care register. There were no care plans in place. We found there was no scanning of DNAR records onto patient notes. We found that formal palliative care meetings had not taken place since May 2015. We found that no information had been disseminated to staff within the practice.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice did not have a robust system in place to check the annual Nursing and Midwifery (NMC) or General Medical Council (GMC) status of registered nurses and general practitioners.

Some staff had undertaken annual appraisals that identified learning needs from which action plans were documented. However nursing and healthcare staff had not received an appraisal since 2013.

The practice did not have a training matrix in place to identify when training was due. On the day of the inspection nursing staff told us that they had two days mandatory training a year but were unable to do any other training relevant to their role due to lack of time. However non clinical staff had undertaken a two day training course annually which covered all mandatory training.

Working with colleagues and other services

We found that the practice did not have a robust system for checking and acting on abnormal pathology results. On the day of the inspection we found a backlog of abnormal results which dated back to 21 September 2015 for the new

Inadequate

Are services effective?

(for example, treatment is effective)

advanced nurse practitioner and a new diabetic specialist nurse. We spoke to a lead GP who told us that the results were always seen first by the patients GP and then left for the nurses to view but there was no record of this.

Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required.

The new practice care co-ordinator was now identifying and coding and adding alerts to the electronic patient record for all patients who were on the unplanned admission caseload. We saw minutes of a meeting held on 19 February and 21 April 2015 where patients were discussed and an appropriate decision made on their future care.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, (those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register). These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw that the practice had a system in place for making referrals and checking that appointments had been made which was working effectively. There was no backlog of dictated referrals as they were completed on a daily basis.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. There was a practice policy for documenting consent for specific interventions.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance.

Health promotion and prevention

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. 44% of eligible patients had received a health check.

The practice's performance for the cervical screening programme was 83.79 %, which was above the national average of 81.88%. The administration team identified patients who had not attended for cervical screening. Patients were contacted by phone or by letter. An alert was also put on the patient's electronic record to remind staff should the patient attend the practice. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

We found that there was no robust or clear system for the recall of children for their childhood immunisations. When we spoke with the practice they were unable to tell us who undertook this role.

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

- Flu vaccination rates for the over 65s were 70.54%, and at risk groups 54.03%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 84% to 93.8% and five year olds from 55.5% to 91.1%. In most age ranges they were comparable to CCG/National averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the July 2015 national patient survey and the NHS Friends and family test (FFT)

Results from the July 2015 national patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average in most areas for its satisfaction scores on consultations with doctors and nurses. For example:-

- 94% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 87% and 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 national average of 95%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

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

There were male and female GPs in the practice therefore patients could choose to see a male or female doctor.

Reception staff were aware that confidentiality was difficult due to the layout of the reception area. We saw that staff were careful to when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. Additionally, 92% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 77%.

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

Care planning and involvement in decisions about care and treatment

Results from the July 2015 national patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were above local and national averages. For example:

- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.

87% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%.

Patient feedback from comments cards received told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient's we spoke with were also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website also had the option to translate the information to a vast number of languages.

Patient/carer support to cope emotionally with care and treatment

- The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example: 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.

Good

Are services caring?

- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 92% patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

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

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

The practice did not have a system in place to identify if a patient was a carer. The practice did not have a consistent approach to ensure that carers were recorded and an alert set up on the patient electronic record. From 1998 only 81 patients had been identified as carers. Staff we spoke with told us this was not discussed when patients registered with the practice.

Staff told us that if families had suffered bereavement their usual GP sent them a sympathy card.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- Urgent access appointments were available
- Home visits were available for older patients or patients who would benefit from these.
- There were disabled access and facilities.
- A lift was available for access to the first floor
- Extended hours were available on Tuesday evening and a Saturday morning
- The practice ran an in house musculoskeletal service

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example a review of online access and the appointment system. As a result they found there had been a reduction in waiting times for routine appointments, and online access was expanded.

Access to the service

The surgery was open from 8am to 6pm Monday to Friday. Appointments with a GP were available from 8.50am to 5.30pm Monday to Friday. The practice had extended hours 6.30pm to 8pm on a Tuesday and Saturday 9.am to 11am with prebookable appointments particularly for working people. Urgent on the day appointments were also available with a nurse practitioner.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with substance misuse and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a number of local care homes as required and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example: Results from the July 2015 national patient survey showed that patient's satisfaction with how they could access care and treatment was above average in comparison to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 86% patients said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 73%.
- 78% patients described their experience of making an appointment as good compared to the CCG average of 73% and national average of 73%.
- 79% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a nurse practitioner on the same day if they felt their need was urgent.

Routine appointments were available for booking 12 weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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, for example, complaints leaflet available in reception. A complaints procedure was also available at the reception desk.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at 9 complaints received in the last 12 months and found they were dealt with in a timely way with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. We looked at minutes of meetings but could not see where these had been discussed with staff or where lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was to improve the health, well-being and lives of those they care for. Some of their aims were to provide high quality, safe, professional primary health care general practice services to patients. Focus on prevention of disease by promoting health and wellbeing and offering care and advice to patients.

We spoke with members of staff and most knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a limited governance framework in place to support the delivery of the strategy and good quality care. We found that:-

- The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice.
- There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP partner was the lead for safeguarding.
- The practice did not have a clear or consistent system in place for reporting, recording and monitoring significant events, incidents and accidents.
- The practice did not have in place a programme of continuous clinical and internal audit in order to monitor quality and make improvements.
- There was not a structured or robust approach for dealing with dealing with safeguarding. There was not a robust system in place for checking emergency equipment and medicines including the doctors' bags.
- The practice did not have effective systems to ensure patients and staff were protected from the risk of infection.
- There was not a robust system in place to ensure that the patient group directives (PGD's) were signed by a GP and all relevant members of the nursing team.
- The practice did not have systems and processes in place to monitor the quality of the service and to ensure they were consistently being used and were effective.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. The practice monitored risks on a regular basis to identify any areas that needed addressing.

The practice held monthly staff meetings but we unable to see in minutes we looked at where governance issues, for example, performance, quality and risk were discussed.

We spoke with members of staff and they were all clear about their own roles and responsibilities. Most felt valued, well supported and knew who to go to in the practice with any concerns.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. The practice had a whistleblowing policy which was also available to all staff in the staff handbook.

Leadership, openness and transparency

The practice told us that two full time GP partners had recently left the practice. The practice had applied to NHS England to temporarily close their list whilst they took the necessary steps to increase its capacity to deliver services to patients, for example, employing new GPs and increase the number of appointments. However they had been unsuccessful. Practice lists are held by NHS England and not the individual practice and therefore the agreement to close the list for six months is made by NHS England and not the GP practice.

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. Informal meetings were held each day where staff got in discussions about any concerns and how to develop the practice. Some staff said the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that practice meetings were held every month. Staff told us they had the opportunity to raise

Are services well-led?

Inadequate

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

any issues at team meetings and felt confident in doing so and felt supported if they did. Most staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged feedback from patients. It had gathered feedback from patients through the virtual patient participation group (PPG), the NHS Friends and Family Test (FFT) and complaints received. The practice were in the process of trying to form an actual PPG as opposed to a virtual PPG. The practice had approached the virtual PPG members to identify areas of concern and as a result of their feedback had reviewed online access and the appointment system and as a result found there had been a reduction in waiting times for routine appointments, and online access was expanded. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice had not carried out a patient survey since 2014. We spoke with the management team who told us that they will plan to do another patient survey, check comments on NHS Choices and continue with family and friends testing.

The practice had gathered feedback from staff through staff meetings and appraisals but not always acted on it. Some staff told us there were times when they did not feel supported. Most staff had received an annual appraisal but some staff had not had an appraisal since 2013.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their mandatory two day training each year but did not have the time for clinical professional development through training, mentoring and to attend meetings.

Two members of staff told us they do not have enough time to supervise staff as they are always part of the working team. This had been raised with the management team.

We looked at eight staff files and saw that regular appraisals took place which included a personal development plan for most staff but the nursing and healthcare staff had not receive an appraisal since 2013. Some staff told us that the practice was very supportive of training.

Significant events were discussed regularly at practice meetings but the minutes did not demonstrate that any learning or improved outcomes for patients had taken place.

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 17 HSCA (RA) Regulations 2014 Good governance 17 (1) - Systems and processes must be established and operated effectively to enable you to: 17 (2) - (a) - assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); and (b) - assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was in breach of Regulation 17 (1)(2) (a) (b) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (1) - Service users must be protected from abuse and improper treatment in accordance with this regulation. 13 (2) - Systems and processes must be established and operated effectively to prevent abuse of service users. This was in breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).