Durdells Avenue Surgery

Quality Report

1 Durdells Avenue
Kinson
Bournemouth
BH11 9EH
Tel: 01202 573947
Website: www.durdellsavenuesurgery.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Durdells Avenue Surgery on 7 February 2017 to assess the improvements made at the practice. Overall the practice is rated as inadequate.

We had previously inspected Durdells Avenue Surgery on 15 February 2016 when we rated the practice as requires improvement overall. Specifically, the practice was rated as requires improvement for safe and effective, good for caring and responsive and inadequate for well-led.

Areas which did not meet the regulations following our inspection in February 2016 were:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, risks from fire were assessed but actions to reduce risk were not implemented.
- There were no effective systems for clinical audits to promote learning and improvement to patient outcomes.
- There was no evidence of learning and communication with staff about reported safety incidents or clinical guidelines.
- The practice had limited leadership and limited formal governance arrangements. For example, they had failed to maintain accurate records relating to the requirements for staff training and development. Long-term plans to resolve low staffing were not in place.

On 7 February 2017, our key findings across all the areas we inspected are as follows:

- The practice had no clear leadership structure and limited formal governance arrangements.
- Staff were able to report incidents, near misses and concerns; however wider learning and effective communication across the team.
- Patients were at risk of harm because systems and processes were not being followed to keep them safe as a direct result of staff shortages. For example, not all staff had received training in infection control, chaperone duties for those staff undertaking this role, adult safeguarding and The Mental Capacity Act (2005).
- There remained a lack of effective systems for clinical audits or quality improvement exercises to promote learning and improvement to patient outcomes.

Summary of findings

- Patients were generally positive about their interactions with staff and said they were treated with compassion and dignity. However, some patients reported there was limited continuity of care.
- The practice provided suitable support for patients who were also carers.
- The practice sought feedback from patients.
- Staff were not consistently well supported by management and the staffing arrangements.
- The practice had not displayed the rating of the previous inspection.

The areas where the provider must make improvements are:

- Introduce reliable processes for reporting, recording, acting on and monitoring significant events, complaints, incidents and near misses.
- Address identified concerns with infection prevention and control practice, including legionella.
- Carry out clinical audits, including re-audits and other activity to ensure improvements in patients care and outcomes 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 and which are reflective of the requirements of the practice.
- Ensure patient complaints are investigated in an appropriate manner.
- Ensure sufficient staff are deployed to meet the needs for the safe running of the practice and patient's needs.
- Ensure staff receive the training and support necessary for them to undertake their roles effectively, including regular communication and regular performance reviews.

In addition, there were areas where the practice should make improvement:

- Consider providing additional support to meet the needs of patients with impairments. For example, a hearing loop and improved disabled facilities.

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.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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 as there are improvements that must be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, reviews and investigations were not formally conducted and lessons learned were not communicated widely enough to support improvement.
- Although risks to patients were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, from the risk of legionella and infection control.
- The practice had limited systems for safeguarding, which were not consistently implemented. For example, we found a lack of adult safeguarding training and the practice was unable to demonstrate that clinical staff were trained to the recommended level of child safe-guarding. There was no practice specific protocol for safeguarding.
- The issues above were on-going issues of concern and had not been addressed since our previous inspection in February 2016.

In addition:

- There were not enough staff to maintain patient safety and provide continuity of care. There was only one regular GP covering all of the clinical sessions. Staff were regularly left on their own in the practice without the on-site support of a clinician.
- Processes for managing emergencies were not comprehensive. For example, not all staff had received basic life support training and not all emergency equipment was held by the practice.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements must be made.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average. However not all patients with long term conditions were assessed to ensure their care and treatment was correct.

Summary of findings

- There were gaps training that staff needed to carry out their roles safely and effectively. For example for The Mental Capacity Act 2005, basic life support, infection control and adult safeguarding.
- Not all staff had regular appraisals.
- There was no evidence that audit was driving improvement in performance to improve patient outcomes.
- Multidisciplinary working was taking place but record keeping relating to these lacked detail.
- The issues above were on-going issues of concern and had not been addressed since our previous inspection in February 2016.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for several aspects of care.
- Most patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services as there are improvements which must be made.

- Patients said they found it easy to make an appointment with a GP with appointments available on the same day. Patients were able to pre-book appointments with the practice nurse or GP. However, practice systems meant that patients would not always know whether they would see a regular GP or a locum GP.
- Patient reported there was limited continuity of care.
- The practice did not adequately maintain the premises to meet the needs of patients. For example, the patient toilet lid was damaged.
- Information about how to complain was available for patients.
- There was a designated person responsible for handling complaints but the practice did not respond in an appropriate way to issues raised by patients.

Summary of findings

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led as improvements must be made.

- The practice did not have clear a vision and a strategy which was shared with staff. There was a documented leadership structure but not all staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but many of these did not contain practice specific information or were overdue a review.
- The practice sought feedback from patients and had a patient participation group. The ideas of the PPG were not always reviewed.
- There was a lack of effective governance arrangements to ensure the assessment of quality of care and delivery of improvements. The practice did not hold regular governance meetings.
- There was no evidence of appraisals or personal development plans for staff. Some appraisals were booked for Spring 2017.
- The issues above were on-going issues of concern and had not been addressed since our previous inspection in February 2016.

In addition:

- Staff had formally raised concerns with the practice leadership, but these had not been responded to in an appropriate manner.

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 provider was rated as good for caring and inadequate for safe, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good caring practice.

- The practice offered home visits and on the day appointments.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older patients were similar to national averages. For example, 93% of patients with chronic obstructive pulmonary disease, a lung condition, had a review within the previous 12 months compared to the clinical commissioning group (CCG) average of 92% and national average of 89%. However, exception reporting for this figure was 22% which was higher than CCG and national averages.
- The practice regularly reviewed patients who had unplanned admissions to hospital, to ensure their needs were met.

People with long term conditions

Inadequate

The provider was rated as good for caring and inadequate for safe, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good caring practice.

- The practice nurse had a lead role in chronic disease management.
- Performance for diabetes related indicators was similar to the Clinical Commissioning Group (CCG) and national average. For example, 94% of patients with diabetes had an acceptable blood pressure reading recorded in the preceding 12 months compared to a CCG average of 93% and a national average of 91%. However, exception reporting for some diabetes indicators was higher than the CCG and national average.
- All these patients had a named GP.

Families, children and young people

Inadequate

The provider was rated as good for caring and inadequate for safe, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good caring practice.

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were mixed for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 80%, which was comparable to the Clinical Commissioning Group average of 83% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- There was a designated information board aimed at families, children and young people.
- The practice worked with other professionals to ensure the needs of this group were met. For example, we saw evidence of meetings with health visitors.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as good for caring and inadequate for safe, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good caring practice.

- The practice offered online services and health promotion and screening that reflects the needs for this age group.
- The practice offered catch up immunisations for students aged 17 and above.
- Extended hours appointments via the walk-in service were offered every Tuesday until 7pm.
- The practice offered on-line booking of appointments.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as good for caring and inadequate for safe, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good caring practice.

- The practice worked with multi-disciplinary teams in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice did not keep a register of patients with a learning disability; we were told there were no patients with a learning disability registered at the practice.

Summary of findings

- Staff could describe how to recognise signs of abuse in vulnerable adults and children. However, there was a lack of safeguarding training and appropriate safeguarding processes in the practice were not embedded. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as good for caring and inadequate for safe, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good caring practice.

- A total of 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is higher than the CCG average of 86% and the national average of 84%. Exception reporting for this indicator was lower than CCG and national averages.
- A total of 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the last 12 months. This was higher than the CCG average of 89% and the national average of 88%. Exception reporting for this indicator was lower than CCG and national averages.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had not undergone training in The Mental Capacity Act 2005.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in January 2017. Altogether, 220 survey forms were distributed and 94 were returned. This represented approximately 3% of the practice's patient list. The results showed the practice was performing in line with or above local and national averages.

- 96% found it easy to get through to this surgery by phone compared to a clinical commissioning group (CCG) average of 84% national average of 73%.
- 93% were able to get an appointment to see or speak to someone the last time they tried, compared to a CCG average of 89% and a national average of 85%.
- 91% described the overall experience of their GP surgery as good, compared to a CCG average of 90%, and a national average of 85%.
- 84% said they would recommend their GP surgery to someone who has just moved to the local area, compared to a national average 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 16 comment cards which were mainly positive about the standard of care received. Patients commented on how helpful and caring reception staff were and of the efficient service received. Most commented on how they were treated with dignity and respect by clinical staff and how they had no complaints about the practice. However, some comment cards related to the dismissive attitude of a particular GP. There were also some negative comments regarding a lack of continuity of care.

We spoke with six patients during the inspection. Most patients said they would recommend the practice and were happy with the care they received and thought staff were approachable, committed and caring. Some found the waits for walk-in clinics frustrating. One patient commented on feeling rushed in appointments by the GPs and another commented that the attitude of one of the GPs was poor. One patient commented on the poor cleanliness of the practice; however other patients found this to be acceptable.

Durdells Avenue 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 an assistant inspector.

Background to Durdells Avenue Surgery

Durdells Avenue Surgery is located at Durdells Avenue, Kinson, Dorset BH11 9EH.

Durdells Avenue Surgery is based in a residential area of Kinson, Bournemouth, and is part of NHS Dorset Clinical Commissioning Group (CCG). The practice is in a purpose-built two storey building. Durdells Avenue Surgery provides services under a NHS Personal Medical Services contract to approximately 3000 patients living within the practice boundary. The practice is located in an area of greater deprivation compared to the average for England and has a higher proportion of older patients compared to the average for England.

The practice has two male GP partners. One GP works part-time and does not offer regular clinical sessions, which had been the case over the last 12 months. The practice employs locum GPs, some of whom were male and some were female, to cover clinical sessions. The GPs are supported by a female practice nurse. The clinical team are supported by a business manager and a team of eight secretarial and reception staff. The business manager is full-time and staff reported that the business manager works approximately one to two days a week on-site.

Durdells Avenue Surgery is open between 8.30am and 6.30pm Monday to Friday. Phone lines open at 8am. Extended hours surgeries are available every Tuesday evening until 7pm. The practice offers a 'walk-in' clinic, where patients do not have to pre-book appointments, every day from 9am until 10am and from 2pm until 4pm on Mondays, Wednesdays and Fridays. Patients who attend the walk-in clinic are seen in order of arrival. Patients are also able to pre-book appointments with the GP or practice nurse. The GP also performs daily home visits to patients who are unable to attend the practice at the end of the morning walk-in clinic.

Durdells Avenue Surgery has opted out of providing out-of-hours services to their own patients and refers them to the Boscombe and Springbourne Health Centre (based in Bournemouth) walk in service at weekends, and the Dorset Urgent Care service via the NHS 111 service. The practice offers online facilities for booking of appointments and for requesting prescriptions.

Why we carried out this inspection

Durdells Avenue Surgery was previously inspected by the Care Quality Commission on 15 February 2016. Following this inspection, the practice was given a rating of requires improvement overall.

Two requirement notices were issued listing areas where improvement was required. The provider was required to submit to us an action plan detailing what action they would be taking to meet the regulations. The practice did not submit an action plan. We carried out a further comprehensive inspection of the services under section 60

of the Health and Social Care Act 2008 as part of our regulatory functions to monitor ongoing compliance and determine whether the requirements notices made in February 2016 had been met.

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 7 February 2017. During our visit we:

- Spoke with a range of staff including a GP partner, locum GP and support staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- 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.

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 living 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

At our inspection in February 2016, we found the system for reporting and recording significant events was not safe. Significant events were rarely recorded formally and there was no consistent documentation of discussions around significant events to improve safety.

At this inspection in February 2017, there had been some improvements in the reporting and recording of significant events, but this was not embedded. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Staff told us they would inform the business manager of any incidents. There had been six significant events in the past 12 months. Clinical staff were able to describe significant events to us and that appropriate action was taken. For example, some clinical information was sent to a GP who was on long-term absence and so was not actioned for eight months. The practice changed their processes to ensure that clinical workflow would no longer be sent for absent GPs to action.

- The practice had developed a protocol for significant events in 2009. There was no indication of a review date on the document. The protocol stated that events would be reviewed in meetings.
- There had been a documented discussion of significant events at one staff meeting since our last inspection in February 2016. However, the minutes of the meeting were not sufficiently detailed to determine what learning had taken place or actions taken to improve the quality of care. For example, there were no details regarding the number of significant events that had been discussed or what the discussions related to.

Overview of safety systems and processes

At our inspection in February 2016, we found that the practice did not have consistently clear defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse. Staff were able to describe their responsibilities with regard to safeguarding, however we found there was not an effective system to record staff safeguarding training. We found that the practice could not demonstrate that all staff had completed safeguarding training that was relevant to their role and up to date.

At our inspection in February 2017, the practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, but we found that these were still not embedded:

- Some arrangements were in place to safeguard children and vulnerable adults from abuse. There were no practice specific safeguarding policies for staff to refer to. The clinical commissioning group policies for adult and child safeguarding were available, however these did not provide practice specific information for staff.
- There was a lead member of staff for safeguarding. However, staff told us they would not routinely report any safeguarding concerns to this person[EJB1] and would instead report to their line manager. None of the staff had received training in adult safeguarding. The practice could not demonstrate that all staff had received child safeguarding training to the appropriate level. We asked the practice to submit evidence of level 3 training for GPs and level 2 training for nurses within 48 hours of our inspection. The practice did not submit this information.
- The practice had conducted a safeguarding audit in March 2016 which identified that some areas required improvement. At the time of our inspection, the audit had not been repeated to monitor progress and the practice did not show evidence of any actions taken to make improvements.
- A notice in the waiting room and clinical rooms advised patients that chaperones were available if required. The practice did not have a chaperone policy. We were told that the nurse acted as a chaperone, however when she was not available reception staff had been asked to chaperone. The practice had not ensured that reception staff received training for this role.
- All staff had received a Disclosure and Barring Service check (DBS). A DBS check to identifies 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 did not maintain appropriate standards of cleanliness and hygiene. We observed that not all areas in the premises were clean and tidy. For example, the patient toilet was visibly dirty. Some patients also commented to us that the practice did not feel clean.
- The measures for infection control were not effective. The practice could not demonstrate that staff had received up to date training in infection control. The

practice nurse had last undergone this training in 2012 and there were no records of infection control training for other staff. The practice policy stated this would be carried out annually. There had not been an infection control audit since January 2016. Areas identified in this audit were still to be completed. For example, there was damaged seating in the patient waiting area and the practice did not show evidence of actions taken to arrange repairs or replacements.

- We found three clinical sharps boxes (for the safe storage of used needles and other sharp instruments) that had not been changed since September 2015, December 2015 and January 2016. Guidance recommends these should be changed every three months to minimise the risk of infection.
- The practice had started a hand hygiene audit in November 2016 to monitor the effectiveness of hand-washing, but records for this were not complete.
- The practice could not be assured that their policy for handling body fluids and spillages was relevant. The policy was dated September 2009 and had been due for review in September 2013; this had not been achieved.
- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- There were systems in place to monitor the use of blank prescription pads. However, we observed that blank prescription stationery in clinical areas was not consistently stored securely. We found blank prescription stationery in a printer tray in a room which was not locked. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- The practice had not employed any new staff employed since our previous inspection in February 2016. At our previous inspection, we found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

At our inspection in February 2016, risks to patients were not consistently assessed and well managed. Actions required to improve fire safety had not been conducted by the practice. For example, there was no electrical safety certificate of the building and weekly tests of fire alarms and regular fire drills were not conducted. The practice had not conducted an assessment to determine the risk of infection from Legionella (Legionella is a particular bacterium which can contaminate water systems in buildings and cause breathing difficulties).

At this inspection in February 2017, there were some arrangements for monitoring risks to patients and staff:

- There was a health and safety poster in the reception office and other staff areas which identified local health and safety representatives.
- There was a current gas safety certificate dated 30 September 2016.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Clinical equipment had been appropriately maintained and calibrated, most recently in June 2016.
- The practice had provided fire safety training to staff in September 2016. A designated fire marshal had also received appropriate training in September 2016. The fire marshal carried out weekly tests of the fire alarms and monthly checks of fire extinguishers.

However, the procedures in place for monitoring and managing risks to patient and staff safety were not consistently effective:

- The practice carried out a risk assessment for in 2011 which identified that the practice should obtain an electrical safety certificate for the building. There was no evidence to show that this had been carried out by the practice. This had been identified at our previous inspection in February 2016.

Inadequate

Are services safe?

- The health and safety policy lacked any practice specific detail, was not dated and did not include a date for when this would be reviewed to ensure current procedures were reflected.
- The fire risk assessment was dated October 2011 and had been due for review in 2012. This risk assessment recommended that six doors should be replaced to comply with standards for fire doors. There was no evidence that this work had been completed. There was no practice specific fire policy; the practice identified the clinical commissioning group fire safety policy as the practice policy. However, this policy did not contain any site specific information for the practice.
- The practice had carried out a legionella assessment in October 2016 (legionella is a term for a particular bacterium which can contaminate water systems in buildings and cause breathing difficulties). The assessment found the practice to be at high risk of infection from legionella. Recommended actions to minimise the risk of infection had not been carried out by the practice. For example, there were no records of monthly temperature monitoring of water or weekly flushing of water outlets. There were no records of an annual clean and disinfection of the water storage tanks.
- The practice provided to us after our inspection, a copy of an agreement between a contractor and the practice to undertake remedial works and to support the practice with regular monitoring of water systems to reduce the risk of legionella. The agreement was signed 13 February 2017. The practice were unable to confirm when this work would commence.
- There was a rota system in place for non-clinical staff which facilitated the learning of different administration roles. This meant that non-clinical staff were able to cover for each other for periods of sickness and absence.
- There were no safeguards in place for patients in the event of the sickness or absence of clinical staff. Staff told us that the presence of the GP partners at the practice varied from week to week.
- The box for patients to leave requests for repeat prescriptions was not locked which meant that sensitive patient information was not kept securely.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents, but these were not consistently safe.

- Not all clinical staff had received annual training in basic life support. All non-clinical staff had received training in April 2016.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We saw evidence that this was checked regularly by staff. Emergency equipment we checked was fit for use.
- Some emergency medicines were easily accessible to staff in a secure area of the practice and all staff we spoke to knew of their location. All the medicines we checked were in date and fit for use. However, the practice did not keep a full complement of emergency medicines or equipment as recommended by national guidance, such as cannulas (for venous access) airways, fluids and atropine (a medicine to correct a slow heart rate) nor a risk assessment to explain why this was not the case.
- Non-clinical staff were, on occasion, left alone in the premises without clinical support. On our inspection, a member of staff was on their own whilst the practice was open over lunchtime. We were told that GPs could be absent for two to three hours whilst conducting daily home visits. This meant they were unsupported in the event of an emergency, were a patient to seek assistance. No risk assessment had been conducted with regard to this.
- 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. This had been updated in November 2016, however referred to out of date information, such as the Primary Care Trust (these were dissolved in 2013).

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

At our last inspection, we found that the practice did not have formal systems in place to keep all clinical staff up to date. Guidelines were discussed on an ad hoc basis and there was a lack of formal educational meetings. Therefore the practice could not provide assurance that guidelines were consistently implemented and their impact monitored.

At this inspection in February 2017, we found that the practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. However, the practice did not have formal systems in place to keep all clinical staff up to date. The practice was unable to demonstrate that guidelines were consistently implemented and their impact monitored.
- The practice undertook a virtual ward for patients who were at high risk of admission to hospital and attendance at accident and emergency departments to ensure care and treatment was appropriate and to minimise admissions.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.5% of the total number of points available, with 15% overall clinical 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). Overall clinical exception reporting was higher than the CCG average of 13% and national average of 10%. This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2015 to the end of March 2016 showed;

- Performance for diabetes related indicators was similar to the Clinical Commissioning Group (CCG) and national average. For example, 87% of patients with diabetes had an acceptable average blood sugar level recorded compared to a CCG average of 82% and a national average of 78%. However, exception reporting for this indicator was 34%, which is higher than the CCG average of 18% and national average of 13%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average. The practice achieved 82% compared to a national average of 81%.
- Performance for mental health related indicators was better than the CCG and national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented, in the preceding 12 months was 95%. This compared to a CCG average of 91% and a national average of 89%. Exception reporting for this indicator was 9%, which is lower than the CCG average of 15% and national average of 13%.
- The practice had a greater number of patients diagnosed with cancer, compared to the CCG and national averages. The percentage of patients with cancer who had a review within six months of diagnosis was 100% compared to the CCG of 96% and national average of 95%. However, exception reporting for this indicator was 41%, which is higher than the CCG average of 32% and national average of 25%.

At our inspection in February 2016, the practice had limited evidence to demonstrate that clinical audits resulted in quality improvement. We were told that audits supported by the CCG were conducted, but the practice were unable to show us evidence of this. The practice had conducted one additional audit regarding the prescribing of tramadol, a medication for pain relief, but at the time of our inspection had not re-audited to see if any improvements to practice had been sustained.

At this inspection in February 2017, we found limited improvement at monitoring outcomes for patients:

- The practice told us they conducted medicine audits supported by the Clinical Commissioning Group (CCG) related to the prescribing of medicines. The practice were able to provide evidence that the CCG audits were being conducted, but were unable to demonstrate the impact these audits had had on patient outcomes.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice were unable to provide us with examples of other clinical audits or activities to support improvement to patient outcomes.

Effective staffing

At our last inspection in February 2016, the practice did not keep records relating to the training of staff. Training of staff took place on an ad hoc basis. This meant the practice could not be reassured that staff had the skills necessary to deliver effective care and treatment. There was limited evidence that staff completed the practice induction programme. There was no system for appraisals, no regular meetings or reviews of practice development needs. Staff performance was reviewed on an ad hoc basis. There were no formal appraisals or one-to-one meetings. Some appraisals had been booked for Spring 2017.

At this inspection in February 2017, we found that:

- The practice had a staff handbook which detailed procedures for sickness and absence, grievances and disciplinary matters, however the handbook had not been updated since 2008.
- The practice could not demonstrate how they ensured role-specific training for staff. There was no oversight of the training needs and requirements of staff. Nursing staff took responsibility for ensuring they kept up to date with relevant training, for example for managing long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at meetings.
- The learning needs of staff were not systematically identified. For example, there were no regular meetings or reviews of practice development needs. Staff had access to appropriate training to meet their learning needs, however this was not monitored by the practice. There had still been no formal appraisals since our last inspection. Some appraisals were booked for February 2017.
- The practice were unable to demonstrate that all staff had received training in areas they considered to be mandatory such as safeguarding, Mental Capacity Act 2005, infection control and basic life support. Staff had access to e-learning training modules, however these were not monitored by the practice leadership team to ensure completion.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Investigation and test results were reviewed by one of the partner GPs. However, the partners worked variable hours from week to week and we could not find evidence that a failsafe system was in place to ensure these were actioned in a timely manner.
- Information such as NHS patient information leaflets were available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis.

Consent to care and treatment

Staff did not consistently seek patients' consent to care and treatment in line with legislation and guidance.

- It was not clear that staff understood the relevant consent and decision-making requirements of legislation and guidance.
- When providing care and treatment for children and young people, staff did not consistently carry out assessments of capacity to consent in line with relevant guidance.
- The practice had not ensured that all clinical staff received training in the Mental Capacity Act 2005. Of four clinical members of staff, three had no documented training. One member of non-clinical staff had undergone the training.

Inadequate

Are services effective?

(for example, treatment is effective)

Supporting patients to live healthier lives

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

- These included carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- Dietary and smoking cessation advice was available from the practice nurse.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 83% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. A total of 70% of eligible women attended screening for breast cancer compared to a CCG average of 76% and a national average of 72%. A total of 55% of eligible patients were screened for bowel cancer compared to a CCG average of 64% and a national average of 58%.

Childhood immunisation rates were mixed compared to national averages. For example, childhood immunisation rates for four vaccines given to under two year olds ranged from 58% to 100%; the national expectation for coverage of these immunisations is 90%. However, 100% of children under five received both immunisations for MMR compared to the national average of 88%.

Patients had access to appropriate health assessments and checks. The practice nurse conducted health checks for new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the 16 patient Care Quality Commission comment cards we received, 13 comments were wholly positive about the service experienced. Patients commented upon the helpfulness of staff and the friendly atmosphere, and the positive aspects of the walk-in service. Negative comments related to the attitude of a GP and a lack of continuity of care.

Results from the national GP patient survey published in July 2016, showed patients felt they were treated with compassion, dignity and respect. The practice was in line with CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% said the GP was good at listening to them, compared to the CCG average of 92% and national average of 89%.
- 89% said the GP gave them enough time, compared to the CCG average of 90% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw, compared to the CCG average of 97% and national average of 95%.
- 90% said the last GP they spoke to was good at treating them with care and concern, compared to the CCG average of 89% and national average of 85%.
- 96% said the last nurse they spoke to was good at treating them with care and concern, compared to the CCG average of 93% and national average of 91%.

Care planning and involvement in decisions about care and treatment

We spoke to six patients during our inspection. Most patients told us they felt involved in decision making about the care and treatment they received. Most 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. One patient told us they felt rushed during consultations and another patient felt the attitude of one GP was poor. Patient feedback on the comment cards we received was mostly positive and aligned with these views. 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 or above local and national averages. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average 82%.
- 95% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- 91% say the last nurse they saw or spoke to was good at involving them in decisions about their care, compared to the CCG average of 88% and national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Information leaflets on the practice website were also available to patients in different languages.

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

Patient and carer support to cope emotionally with care and treatment

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 69 patients as carers which is just over 2% of the practice list. The practice used a specific form to help identify which patients were also carers. Written information was available to direct carers to the various avenues of support available to them via a specific information board. The practice had an active

Good

Are services caring?

'carers lead' whose role it was to update resources for carers, liaise with the clinical commissioning group about the needs of carers and to maintain the carers register in the practice.

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice offered extended hours for pre-bookable appointments on a Tuesday evening until 7pm for patients who could not attend during normal opening hours.
- Home visits were available for older patients and patients who would benefit from these, for example patients who had recently been discharged from hospital. The practice typically conducted two to three home visits per day.
- Same day appointments were available to all patients, via the daily walk-in clinics.
- There were translation services available. There was no hearing loop for patients with hearing difficulties.
- The practice housed a chiropodist service one to two times per week.
- There were disabled facilities for patients. However, we found the toilet lid to be broken and left on the floor.
- Information for patients in the practice regarding the appointments available to them was unclear. We found the patient information board displayed appointment information for 2010 and 2011. There was a leaflet with opening times dated from January 2017 available behind reception. Patients could book an appointment with a particular GP, but this could be changed for an appointment with a locum GP without the patient being notified. This meant that patients did not know which clinician they were seeing, or of their gender.
- We noted that the practice did not respond to comments left by members of the public on the NHS Choices website.

Access to the service

Patients could make appointments in person, via the telephone or on-line. The practice was open between 8.30am and 6.30pm Monday to Friday. The reception and phone lines were open at 8am. Extended hours appointments were available every Tuesday evening until 7pm.

The practice offered a daily 'walk-in' clinic, where patients do not have to pre-book appointments, every day from 9am until 10am and from 2pm until 4pm on Mondays, Wednesdays and Fridays. Patients who attended the walk-in clinics were seen in order of attendance by the GP. Pre-bookable appointments were also available with the practice nurse or GP.

Results from the national GP patient survey published in July 2016, showed that patient's satisfaction with how they could access care and treatment was generally positive. Survey findings showed:

- 86% of patients were satisfied with the practice's opening hours compared to the CCG average of 84% and national average of 73%.
- 69% patients feel they do not normally have to wait too long to be seen compared to the CCG average of 61% and national average of 58%.
- 89% describe their experience of making an appointment as good compared to a CCG average of 81% and a national average of 73%.
- 97% said they found the receptionists at the practice helpful, compared to the CCG average of 91% and national average 87%.
- 100% said the last appointment they got was convenient, compared to the CCG average of 94% and national average of 92%.

However, one indicator was below local and national averages:

- 39% of patients said they usually get to see or speak to their preferred GP compared to a CCG average of 67% and a national average of 59%.

Patients told us on the day of the inspection that they were able to see a GP on the same day by using the walk-in clinics. Patients commented that this was a positive aspect of the practice.

Listening and learning from concerns and complaints

The practice system for handling complaints and concerns was not effective.

- Its complaints procedures were not in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated person who handled all complaints in the practice, however we found that complaints had not been responded to satisfactorily. For example, there was a complaint raised by NHS

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

England on behalf of a patient which required a response by January 2017. At the time of our inspection in February 2017, there was no evidence of this response having been completed.

- There was no evidence that the practice conducted an analysis of complaints for trends and to identify where care could be improved.
- The annual complaints submission to NHS England for the period April 2016- March 2017 had been signed as completed on the 1 February 2017 ahead of the submission period.
- We saw that information was available to help patients understand the complaints system. There was a poster displayed in the waiting room outlining the complaints process to patients, as well as information on the practice website and in the new patient pack.
- We were shown 'thank you' cards and letters from patients and carers who were happy with the service offered by the practice.

There was limited evidence that lessons were learnt from concerns or action was taken to improve the quality of care. For example, a patient complained about the care received from a clinical member of staff in August 2016. An acknowledgement of the complaint was sent to the patient, but no further communication had been sent to the patient by the practice. The practice did not inform the clinician involved of the complaint. The clinician learnt of the complaint via a third party and submitted their own response to the patient in December 2016.

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

At our last inspection in February 2016, we found that there was a no forward business plan in place to demonstrate where the practice was doing well and areas it could improve on. The GP partners had been concerned about the future of the practice and low clinical staffing levels. Attempts to secure additional locums or merge with other practices had been explored but had been unsuccessful. The practice had taken steps to mitigate the situation with regard to low staffing levels for GPs by employing two nurse practitioners.

At this inspection in February 2017, the practice no longer employed nurse practitioners. The practice were employing locum GPs for approximately one to two days per week to increase clinical cover. Where possible, the practice used the same locums to help support continuity of care for patients. The practice acknowledged that low staffing was a continuing risk for the practice. The practice had explored possible mergers with other organisations; however at the time of our inspection, plans to secure the future of the practice were not confirmed. There was no detailed or realistic vision and strategy for the practice.

Governance arrangements

At our last inspection in February 2016, we found that the practice did not have an overarching governance framework to support the delivery of good quality care. There were risks to patient safety and missed opportunities to improve patient care because the delivery of care had not been planned or monitored. For example, risk assessments had not been completed and where they had they had not been implemented. Staff training had not been planned for and completed by all members of staff and was not monitored by the leadership team. Staff did not receive regular appraisals, however we were told some appraisals had been booked for Spring 2017. There was a lack of oversight of the training needs and requirements of all staff groups. There was no programme of audit to drive improvement in the practice.

At this inspection in February 2017, we found limited improvements had been made.

- There was still a limited programme of audit to drive improvement in the practice.
- There was no oversight of the training needs of staff. Records were kept for the training of non-clinical staff, however the practice did not have oversight of the training needs of clinical staff or for the business manager. There was a reliance on individual clinicians to identify their training needs and keep up to date.
- The business manager attended meetings with other practice managers in the area.

Leadership and culture

At our last inspection in February 2016, we found that the partners had the experience to run the practice and ensure high quality care, but this had not been delivered upon. The future leadership of the practice was uncertain. Staff told us the practice did not hold regular team meetings, however felt valued and supported by the partners in the practice.

At this inspection in February 2017, one GP works part-time and does not offer regular clinical sessions, which had been the case over the last 12 months. The practice no longer employed any nurse practitioners. This continued to place a great deal of hours and responsibility on this partner. In part due to staff shortages, the practice lacked the ability to ensure high quality care was being provided.

The partnership did not identify any potential risks and mitigate in a timely way. The impact of this was that the practice appeared dysfunctional, which was affecting decision making and effectiveness of communication. This was seen in a number of areas including: gaps in records to ensure effective capture of learning and quality improvement, a lack of employer responsibility and a lack of oversight with regard to the management of risks.

Staff told us that the partners and business manager were not always visible in the practice, but that partners and the business manager were approachable when on site. The future direction of the practice was uncertain, and this was a cause for concern for staff.

- Staff expressed a great deal of loyalty to the practice and many staff had worked at the practice for a number of years. However, the practice had not always respected, valued and supported their staff. For example, we saw evidence that the practice had failed to respond to requests by staff for a meeting to discuss the previous inspection findings and the implications for the practice.

Are services well-led?

Inadequate

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

- We found that the practice had on one recent occasion, not paid their staff at the agreed time point, causing a great deal of anxiety for staff.

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

At our last inspection, we found that feedback from staff was not formally sought. There were no staff meetings or regular appraisals. However, staff told us they felt able to raise and discuss any concerns or issues.

At this inspection in February 2017, we found that staff had not had an appraisal since our last inspection in February 2016. Staff told us that they had been asked to completed pre-appraisal forms and that some staff now had appraisals booked for Spring 2017.

There was no visible display of the ratings awarded to the practice form our last inspection in the patient areas at the practice, nor on the practice website.

The practice sought feedback from patients. There was information for patients in the waiting room on how to leave feedback. There was a suggestion box for patients.

- The practice had gathered feedback from patients through surveys. The practice had a patient participation group (PPG) which had regular face to face meetings. However, we were told that sometimes the group met without a member of staff from the practice. The PPG representative we spoke to was unable to give us examples of where the practice had acted to improve care based on the suggestions of the PPG.
- The practice gathered feedback from staff on an ad hoc basis. There were no regular staff meetings and staff told us that they did not regularly receive appraisals. There had been one staff meeting in February 2017 since our last inspection in February 2016. The minutes of this meeting lacked detail. For example, significant events were discussed, but the learning from this was not recorded. It was not clear who had responsibility for which actions arising from the meeting. Staff told us they would discuss any concerns or issues with colleagues.
- Staff told us that the partners and business manager in the practice were approachable.

Continuous improvement

As at our last inspection, we found that the practice did not proactively support continuous improvement and learning.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014** **Safe care and treatment** **The registered provider did not ensure that all reasonably practicable actions were taken to mitigate risks to the health and safety of service users. For example:** • The practice did not provide all recommended medicines and equipment to deal with emergencies or provide a risk assessment to rationalise this. • There was a lack of effective processes for reporting, recording, acting on andmonitoring significant events, incidents and near misses. There was not an overview of any themes of significant events and processes were not in place to identify or address themes. • Not all staff were trained to the appropriate level of child safeguarding or had received training in adult safeguarding. • There was no protocol for patient examinations which required a chaperone. • Measures to prevent infection were not effective. Some areas of the practice were visibly dirty. There had been an infection control audit in January 2016 which identified areas for improvement and not all actions from this audit had been acted upon. Staff had not received infection control training. • Blank prescription stationery was not kept secure at all times.Health and Safety risk assessments had not been acted upon for electrical safety, fire safety and legionella. **This was in breach of regulation 12 (1) 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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014** **Good governance** **The registered provider did not have suitable systems in place to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).** **Systems did not assess, monitor or mitigate risks related to health, safety and welfare of service users. For example:** • Effective systems for clinical audits to promote learning and improvement were not in place. • They had failed to maintain accurate records relating to the requirements for staff training and development. • Recommendations from risk assessments, including for fire and legionella had not been followed. • Effective systems to disseminate learning from safety, significant events and complaints were not in place. • There was no detailed or realistic vision and strategy for the practice including for managing staffing levels. • The policies which the practice had in place did not reflect current procedures in the practice. For example, the safeguarding policy. • The infection control policy states that staff would receive annual training in infection prevention control. This had not been achieved. • There was a lack of systems for the engagement with staff for formally feedback on service provision. • The complaints process was ineffective and did not meet contractual agreements. • There was no oversight of the training needs and requirements of staff. **This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Maternity and midwifery services

Services in slimming clinics

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA (RA) Regulations 2014

Staffing

- Staff had not received training in adult safe-guarding, infection control, basic life support, chaperone (for those undertaking this role) and The Mental Capacity Act 2005.
- There were no regular appraisals for staff and limited support systems for staff.

This was in breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.