Brookdale Surgery

Quality Report

202 Droylsden Road
Newton Heath
Manchester
M40 1NZ
Tel: 0161 681 4265
Website: www.brookdalesurgery.co.uk

Date of inspection visit: 11 April 2017
Date of publication: 15/06/2017

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?	Inadequate
Are services responsive to people's needs?	Inadequate
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 Brookdale Surgery on 11 April 2017. Overall the practice is rated as inadequate.

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there were no vulnerable patient registers and the safeguarding lead did not have knowledge of the in-house safeguarding processes. There were no care plans in place.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning or communication of the outcomes with staff.
- The practice had no clear leadership structure and there was insufficient leadership capacity and no accountability or responsibility from the lead GP. This was reflected by minimal systems and processes being in place to ensure safety and high quality care. There were limited formal governance arrangements.
- The arrangements for managing medicines in the practice, including emergency medicines and vaccines, were inadequate and solely managed by administrative staff. For example, the practice did not have the basic lifesaving medicines or equipment to treat patients in an emergency.
- The practice had no clear clinical processes for the monitoring of high risk medicines.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others, either locally or nationally.
- The practice did not have a comprehensive business continuity plan in place and staff were unsure what to do in an emergency.

The areas where the Provider must make improvements are:

- Ensure the risks to people's health and safety during any care or treatment are adequately assessed
- Ensure that all clinicians undertake care planning for all at risk patients.

Summary of findings

- Ensure processes are implemented for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure medicines are supplied in sufficient quantities, managed safely and administered to make sure people are safe, including those patients on high risk medicines, emergency medicines and equipment and repeat prescribing.
- Ensure processes are in place to maintain a safe practice environment with regards to the health and safety of patients, for example risk assessments, control of substances hazardous to health (COSHH), cleaning maintenance and infection control.
- Ensure that patients are appropriately safeguarded from abuse by having in place a satisfactory process for reporting, adding alerts, recording and acting on all vulnerable patients in the practice, and ensuring safeguarding training for all staff is in place.
- Ensure there is an accessible system for identifying, receiving, handling and responding to complaints.
- Ensure that an effective governance process is in place that includes adequate quality assurance and auditing systems or processes to keep patients safe.
- Ensure the practice seeks and acts on feedback from people using the service, those acting on their behalf, staff and other stakeholders, to continually evaluate the service and drive improvement.
- Ensure staff received appropriate support, training, professional development and supervision to carry out the role for which they are employed.
- Ensure that accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity are maintained.

In addition the provider should:

- Have a system in place to improve their identification of carers and offer more formal support to carers.
- Implement a Patient Participation Group (PPG) in order to identify and act on patients' views about the service.
- Review the telephone system for patients accessing appointments.
- Make the practice leaflet available in paper format.
- Have regular documented clinical and non-clinical meetings.

We identified serious concerns, and drew these to the provider's attention both during the inspection and immediately afterwards in writing.

Following the inspection and at the commission's request evidence was submitted by the provider to ensure the most serious of issues linked to patient safety were being actioned or reviewed immediately to ensure patient safety was being mitigated. We received evidence that some action had been taken. However we were not completely satisfied that the Provider had immediately actioned all the issues identified.

I am placing this service in special measures. Due to the concerns identified the commission has begun the process in line with our enforcement procedures to prevent the provider from operating the service. Services placed in special measures will be inspected again within six months if they are still operating.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- There was not enough clinical leadership and oversight with regard to the day to day running of the practice to keep staff and patients safe.
- The lead GP and staff were not clear about reporting incidents, near misses and concerns. The practice did not carry out investigations when there were unintended or unexpected safety incidents; lessons learned were not discussed and so safety was not improved. Patients and staff did not receive reasonable support or a verbal or written apology.
- There was insufficient attention to safeguarding children and vulnerable adults. The safeguarding lead did not know how many patients were at risk. For example, the safeguarding lead had no registers, alerts or codes in place for identifying the patients at risk. Training in safeguarding had expired for all staff and the safeguarding lead was not trained to the appropriate level.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. Areas of concern were found in: safeguarding, infection control, medicine management, anticipating events, management of unforeseen circumstances and dealing with emergencies.
- The practice held inadequate emergency medicines to treat life threating emergencies.
- The arrangements for managing all medicines, including emergency medicines and vaccines in the practice were inadequate with administrative staff solely responsible.

Are services effective?

Inadequate

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

- Monitoring of risk assessments, care plans and patient profiling were not maintained by the lead GP.
- The lead GP was unaware how to access the practices chronic disease registers for patients and did not know how to access Quality Outcome Framework (QOF) data.

Summary of findings

- There was no systematic process to fully support locum staff and non-clinical staff in handling clinical follow ups and concerns. For example, the administrative staff were responsible for delegating work to the locums with no clinical support or guidance provided.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others either locally or nationally.
- Administration staff had access to an online learning portal, however, not all staff had completed up to date safeguarding training level one or infection control. The practice could not provide internal checking process for locum staffs training records or registration status, therefore completely relying on the locum agency information provided.

Are services caring?

Inadequate

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

- Data from the national GP patient survey showed patients rated the practice lower than others for several aspects of care. For example, 66% said the last GP they saw was good at treating them with care and concern (CCG average 84%, national average 86%)
- Information for patients about the services available was accessible but only online.
- We observed staff treat patients with kindness and respect, and maintained patient and information confidentiality. However patient comment cards were mixed and one card commented on the practice always having different doctors and nursing staff.
- The practice had not identified any carers within the practice.

Are services responsive to people's needs?

Inadequate

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

- Complaints were not investigated and a written response was not provided to complainants. Patients could get information about how to complain in leaflet form. We reviewed two complaints where the practice had not responded to the patient, resulting in the patients escalating the complaints to NHS England.

Summary of findings

- The lead GP could not demonstrate how they had reviewed the needs of the needs of the local population. For example the lead GP was not aware if the practice had a carers register.
- Some patients comments cards told us appointments were difficult to access.
- There was a website and online services for patients.
- 35% of patients said they could get through easily to the practice by phone compared with the CCG average of 71% and the national average of 73%.

Are services well-led?

Inadequate

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

- There was no clear leadership structure and staff did not feel supported by the lead GP which had a negative impact on safety and high quality care.
- There was no clinical accountability or understanding of the day to day running of the practice by the lead GP. For example, on multiple occasions the lead GP could not answer the questions asked by the inspection team, which resulted in them needing to ask staff for the answers.
- Systems and processes were not effectively operated. The practice did not have effective arrangements to monitor and improve the quality of the service or identify and manage risks.
- The practice did not hold regular governance meetings and issues were discussed ad hoc when the lead GP was in practice.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- The specific training needs of staff were not addressed and there was a lack of support and mentorship for those appointed to extended roles. For example, staff told us they repeatedly asked for help and support to maintain the running of the practice until a new practice manager was appointed.

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 safety of care for older patients was not a priority and there were limited attempts at measuring safe practice.
- Systems for discussing and planning a multi-disciplinary package of care for patients with complex or palliative care needs with other health professionals were not overseen by a clinician.
- The practice did not identify older patients who were approaching the end of life.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line with local and national averages.

People with long term conditions

Inadequate

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

- The practice ran on locum nursing staff that performed tasks highlighted on the system for that day. The practice administrative staff were responsible for the overall chronic diseases management of patients with long term conditions.
- The practice did not review patients with long-term conditions discharged from hospital and their care plans were not in place.
- There were no emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- Structured annual reviews of medicines were not undertaken to check that patients' health and care needs were being met. For example, repeat medicines were issued past the annual review date with no policy or process in place.
- 70% of patients with diabetes, on the register, had a last measured total cholesterol (measured within the preceding 12 months) of 5 mmol/l or less compared to the CCG average of 69% and national average of 70%.

Families, children and young people

Inadequate

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

- There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk.

Summary of findings

- Not all staff had been trained in safeguarding children. The lead GP was not trained to the appropriate level.
- 75% of eligible women had received a cervical screening test in the preceding five years, compared to the CCG average of 78% and national average of 81%.

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 surgery is part of the GP Access scheme offering extended hours and weekend appointments to patients.
- NHS Health checks were available to this population group.
- The practice offered online services such as on-line appointment booking and prescription requests.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

- The practice did not hold a register of patients living in vulnerable circumstances.
- The lead GP was unaware how to locate the practice's chronic disease management registers to view vulnerable patients.
- The practice did not identify those whose circumstances may make them vulnerable who were approaching the end of life.
- Staff knew how to recognise signs of abuse in vulnerable adults and children, but the safeguarding lead was not aware of their responsibilities regarding how to record information correctly within the clinical system.

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).

- 79% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, compared to the CCG average 87% and the national average of 84%.
- There was no system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.
- The practice had no system for monitoring repeat prescribing for patients receiving medicines for mental health needs.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was usually performing below local and national averages. 358 survey forms were distributed and 99 were returned. This represented 4% of the practice's patient list.

- 58% of patients described the overall experience of this GP practice as good compared to the to the CCG average of 82% and the national average of 85%.
- 77% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 73% and the national average of 76%.
- 35% of patients found it easy to get through to this practice by phone compared to the CCG average of 71% and national average of 73%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which contained mixed reviews about the standard of care received. One comment card stated that they never saw the same GP or nurse and felt the GP did not have time to explain their test results to them. Another comment card stated that the staff were kind and helpful.

The practice Friends and Family Test (FFT) results showed that between January and December 2016 there had not been any respondents. We spoke to one member of staff who had been appointed the role to manage FFT data. They told us that they had not been given any training on how to action or submit this data and therefore could not complete the job fully.

Areas for improvement

Action the service MUST take to improve

The areas where the Provider must make improvements are:

- Ensure the risks to people's health and safety during any care or treatment are adequately assessed
- Ensure that all clinicians undertake care planning for all at risk patients.
- Ensure processes are implemented for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure medicines are supplied in sufficient quantities, managed safely and administered to make sure people are safe, including those patients on high risk medicines, emergency medicines and equipment and repeat prescribing.
- Ensure processes are in place to maintain a safe practice environment with regards to the health and safety of patients, for example risk assessments, control of substances hazardous to health (COSHH), cleaning maintenance and infection control.
- Ensure that patients are appropriately safeguarded from abuse by having in place a satisfactory process for reporting, adding alerts, recording and acting on all vulnerable patients in the practice, and ensuring safeguarding training for all staff is in place.
- Ensure there is an accessible system for identifying, receiving, handling and responding to complaints.
- Ensure that an effective governance process is in place that includes adequate quality assurance and auditing systems or processes to keep patients safe.
- Ensure the practice seeks and acts on feedback from people using the service, those acting on their behalf, staff and other stakeholders, to continually evaluate the service and drive improvement.
- Ensure staff received appropriate support, training, professional development and supervision to carry out the role for which they are employed.
- Ensure that accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity are maintained.

Summary of findings

Action the service SHOULD take to improve

In addition the provider should:

- Have a system in place to improve their identification of carers and offer more formal support to carers.
- Implement a Patient Participation Group (PPG) in order to identify and act on patients' views about the service.
- Review the telephone system for patients accessing appointments.
- Make the practice leaflet available in paper format.
- Have regular documented clinical and non-clinical meetings.

Brookdale 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.

Background to Brookdale Surgery

Brookdale Surgery is located on the outskirts of Manchester city centre. The practice is based in an end terrace converted two storey house. On the ground floor the practice has been extended and is accessible to patients. The first floor is used by staff and holds a weekly baby weighing clinic. The building and consulting rooms are accessible to patients with mobility difficulties.

At the time of our inspection 2577 patients were on the practice list. The practice is a member of Manchester Health and Care Commissioning. It delivers commissioned services under a General Medical Service (GMS) contract.

The male life expectancy for the area is 73 years compared with the CCG averages of 73 years and the national average of 79 years. The female life expectancy for the area is 79 years compared with the CCG averages of 78 years and the national average of 83 years.

The practice is situated in an area at number one out of ten on the deprivation scale (the lower the number, the higher the deprivation). People living in more deprived areas tend to have greater need for health services.

The practice is run by a single handed male GP and five administrative staff. The lead GP worked one full day and two half days in the practice. All other sessions are covered by a locum doctors. There are a lot of staffing issues at the practice; currently the practice has a regular locum doctor working at the practice two days a week to cover clinics. The practice has no practice nurse and has been using locum nursing staff for the last six months. The practice has had no practice manager for over 12 months. Both the role of the practice nurse and practice manager are currently being advertised.

The practice is open from 8am until 6.30pm Monday, Tuesday, Thursday and Friday and Wednesday 8am until1pm. Appointment times are Monday9am until 11.50am and 4pm until 6pm. On Tuesday, Thursday and Friday they are 9am until 11.30am and 4pm until 6pm. On Wednesday they were 8.50am until11.20am due to the practice being closed in the afternoon.

Patients requiring a GP outside of normal working hours are advised to call " Go-to- Doc" using the usual surgery number and the call is re-directed to the out-of-hours service. The surgery is part of the GP Access scheme offering extended evening and weekend appointments to patients.

The practice is registered to deliver the regulated activities of diagnostic and screening procedures, maternity and midwifery services and treatment of disease, disorder or injury.

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. The inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations and key stakeholders such as Manchester Health and Care Commissioning to share what they knew about the practice.

We reviewed policies, procedures and other relevant information the practice provided before the day. We also reviewed the latest data from the Quality and Outcomes Framework (QOF) and the national GP patient survey We carried out an announced visit on 11 April 2017.

During our visit we:

- Spoke with a range of staff including the lead GP, locum nurse and administration staff.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed a number of policies and processes.
- Looked at information the practice used to deliver care and treatment plans.

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

There was no system in place for reporting and recording significant events to guarantee that sharing, learning, changing, actioning and the overall reviewing of all incidents was taking place. The practice had no clinical lead responsible for overseeing the process.

- The practice did have a standard form where events were documented, which had a brief description of the event. These were completed by the administrative staff and no clinician had final sign off or input. The clinician told us that staff were told to discuss any incidents between themselves.
- There were inconsistencies about what should be reported as an event by staff.Staff had not received any support or training to identify significant events or the recording of them. For example, staff were unclear between the difference of an incident and significant event. We were told of an incident where two patients had physically assaulted each other in the waiting room and the police were called. This had not been recorded as a significant event. The lead clinician told us that they had recorded this in the patients' records, along with adding an alert in to the patients' records. When we reviewed the records this had not been documented.
- The practice did not have a process to follow up or analyse outcomes after significant events had taken place. The lead GP was not able to recall any significant events and was unaware of the process relating to the recording of an incident or significant event. We were told by the clinician that they held meetings and had minutes of these meetings. However, evidence could not be provided and staff told us the practice did not hold meetings.

We could find no formal process in place to distribute and take action in response to medical alerts, incident reports or updated national guidance. We saw that the practice did not have an effective process for tracking or monitoring the completion of actions required. For example, one member of staff did receive alerts and forwarded these to the clinician but these were not recorded and outcomes not detailed.

Overview of safety systems and processes

The practice had no defined or embedded systems, processes and practices in place to minimise risks to patient safety.

- The lead clinician was the practice's safeguarding lead; however staff members were unclear who the practice lead was.
- The safeguarding lead was unable to inform the inspection team how many children or adults were at risk in the practice. The safeguarding lead had to interrupt two staff members' interviews to find out the answer.
- There were no formal meetings to discuss safeguarding concerns. There was a lack of awareness of the importance of and identifying at risk children and vulnerable adults within the practice and between staff.
- The safeguarding lead did not know where the safeguarding policy was kept in the practice.
- The safeguarding policy was out of date and needed renewing in February 2016 and the policy contained reference to the previous practice manager.
- The safeguarding lead had not completed safeguarding training to the appropriate level. Other staff members' safeguarding training had expired in February 2016. Staff interviewed demonstrated they understood their responsibilities regarding safeguarding.
- The safeguarding lead attend safeguarding meetings when possible or provided reports where necessary for other agencies.

Following the inspection evidence was submitted by the provider to confirm that action had been taken to identify vulnerable patients.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice had not maintained appropriate standards of cleanliness and hygiene. We observed the premises to be in need of a full clean and declutter.

- The practice did not have an infection prevention and control (IPC) lead. There was no IPC protocol or policy in place and staff had not received up to date training. We

observed curtains were used to maintain privacy in the treatment rooms. There was a curtain policy which stated they were last cleaned on the 01/04/2017. We were told the lead GP takes them home to be cleaned.

- There were no control of substances hazardous to health (COSHH) procedures followed. We were told by the lead GP that the practice hires an external cleaner who follows NHS cleaning standards, has a cleaning schedule and attended the practice five days per week. However there was nothing to assure the practice that this was what correct. The practice staff told us the cleaner attended between three to four times a week. The cleaning cupboard contained two mop buckets and two mop heads which were dirty. No infection control audits were undertaken.
- The baby weighing room on the 2nd floor needed to be decluttered, a full deep clean and a full safety risk assessment.
- We observed in the patients' waiting room loose hanging blind cords, with no risk assessment checks in place.

Following the inspection evidence was submitted by the provider which ensured the most serious infection control issues identified were being reviewed and actioned immediately.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice were inadequate to ensure risks to patient safety were minimised (including obtaining, prescribing, recording, handling, storing, security and disposal.

There was no process or arrangements for managing medicines, including :

- No vaccination stock rotation or checks taking place
- No serial number checks or process for monitoring blank prescriptions
- No process followed to review expiry dates and repeat prescribing
- No checks on oxygen cylinders

The practice held inadequate emergency medicines in the treatment room and did not have the basic lifesaving medicines or equipment to treat patients such as:

- Nebuliser (a machine to help asthmatic patients when having an asthma attack)
- Benzylpencillin (to treat children with suspected meningitis)
- GTN spray (used to treat chest pain)
- Ventolin Inhaler (used to help relieve asthma attack)
- Overdue medication review dates on repeat prescriptions were not being identified or actioned when patients requested medications. Appropriate action was not always being taken to invite patients in for a review or to limit prescribing where the review date had expired.The staff told us they used the "task" function in the computer system to ask the clinician to review medicines or test results. When we spoke to the lead clinician, they were unaware how to use the medication task within the system.
- The practice had no suitable arrangements in place for monitoring the prescription of Z drugs (a medicine used to treat insomnia) and Hypnotic medicines (a medicine used to relieve anxiety, aid sleep, or have a calming effect), both medicines can be addictive. During the presentation by the practice, the lead GP told us systems and checks were taking place for all high risk drugs.
- We were shown a long list of patients who the medicine management team pharmacist had identified as having possible compliance issues or who would potentially benefit from dose optimisation and drug switches. The information had been passed to the practice in August 2016, but we found these had not been actioned.
- When discussing a potential patient emergency scenario with the lead clinician, there was no assurance that appropriate and timely action would be taken. The scenario presented was "if a patient had collapsed in the waiting room with severe left sided chest pain. What action would you take?". The response was not acceptable and did not include call 999 immediately.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However, we saw that the recruitment of the locum GPs and nursing staff did not follow the same checking process. For example, the practice could not

assure the inspection team that appropriate checks for the locum staff were documented or recorded. The practice took assurance from the locum agency that clinicians checks were up to date and in place. We asked to see the Hepatitis B status of the clinicians in the practice. The locum GP was able to provide their own copy on the day of the inspection and the lead GP provided this evidence after the inspection.

Monitoring risks to patients

There were some procedures for assessing, monitoring and managing risks to patient and staff safety.

- The practice had an up to date fire risk assessment. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had not carried out risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We were told they thought this had been done but they were unable to confirm or locate the paper work.

Following the inspection evidence was submitted by the provider to confirm action was being taken to reduce risk.

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. However, administrative staff were solely responsible for ensuring the locum GP and nurse clinics were covered with no clinical input or support provided.

Arrangements to deal with emergencies and major incidents

The practice had inadequate arrangements in place to respond to non-medical emergencies, with no systems to deal with any major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff annual basic life support training had expired February 2016.
- The practice had no defibrillator available on the premises and no relevant risk assessment was in place.
- The oxygen had adult and children's masks available, but there was no process in place to ensure regular checks were taking place. A first aid kit and accident book were available
- The practice did not have a comprehensive business continuity plan for major incidents such as power failure or building damage. The staff were unsure of what to do in an emergency and were not aware what a business continuity plan was.

We asked the provider to submit evidence immediately to address the most serious issues we had identified. Evidence was submitted by the provider to ensure the most serious of issues identified with medicines management were being corrected or reviewed immediately to ensure patient safety. We carried out an unannounced visit on 24 April 2017 and confirmed that basic emergency medicines were in place.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The lead GP was aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had no systems to keep all locum and regular clinical staff up to date.
- The lead GP had access to guidelines from NICE on his mobile phone.
- The practice had no process that monitored NICE guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients' care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. The practice could provide no evidence of informal or formal individual peer review and support to discuss issues and potential improvements in respect of clinical care.

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 91% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. The overall exception rate was 8.6 % which was lower than the CCG or national averages. (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).

During the inspection we asked the lead GP to show us the practice's chronic disease registers. The lead GP was unware how to access the practice's chronic disease registers for his patients and did not know how to access QOF data. When we asked staff about the management of the QOF registers, we were told it was the responsibility of staff to manage the whole process.

This practice was not an outlier for any QOF (or other national) clinical targets.

- 77% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate, compared to the CCG average 78% and the national average of 78%. The exception reporting rate was 13%.
- 76% of patients with diabetes whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (01/04/2015 to 31/03/2016) compared to the CCG average 77% and the national average of 78%. The exception reporting rate was 6.2%.

The practice was unable to provide evidence of any completed audits where quality improvements made were implemented and monitored. The lead GP was not clear on the difference between an internal patient search and a formal audit cycle.

Effective staffing

- Training for staff was not monitored. Although staff had access to an online learning portal, all but one staff member had not completed up to date training in safeguarding level one or infection control. We reviewed a training certificate which had expired in February 2017, where all staff attended a one day training event- which provided; basic life support training to staff and eight other topics.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, two staff members were presented to the inspection team on multiple occasions by the lead GP, as the practice's temporary practice managers. However, we were told by the two members of staff that they were not acting practice managers and they had never officially been appointed to these positions. They had very little guidance or support on how to carry out the role.

Inadequate

Are services effective?

(for example, treatment is effective)

- The lead GP only had safeguarding training to level two and the required level is a three. Following the inspection the practice provided evidence that this training had been completed to level three.
- We saw that no internal checks of clinical locums' training records were documented. The practice relied on the locum agency information with no internal process or records kept. For example, we were informed the locum clinicians' training was up to date. However, the practice could not provide any evidence to confirm this was factually correct.
- There was evidence of staff annual appraisals taking place. Staff told us that all appraisals were performed the day prior to the inspection and was completed by the lead GP for all staff.

Coordinating patient care and information sharing

The full information needed to plan and deliver care and treatment was not completed in patient records.

- There were no evidence of care planning taking place around planned and unplanned hospital admissions and long term conditions such as dementia or asthma. The lead GP told us they did provide formalised care plans for patients, however he could not provide us with any examples.
- No clinical reviews were taking place of patients who had been discharged from hospital or who had attended accident emergency.
- No documented care plans had been developed by the practice for patients who were at the end of their life. We were told that meetings had taken place with external organisations however these were not documented formerly.
- We identified that risk assessments and patient profiling were not maintained by the lead clinician.
- There was no formal communications or hand over processes between locum staff and the lead GP. There were no regular clinical meetings.

Staff worked 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. The administrative staff attended monthly multi-disciplinary meetings.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However none of the staff had received any formal training in this area.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice had inconsistent approaches to identify patients who may be in need of extra support.

- The practice was not able to ensure that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The inspection team asked the clinician about patients in the last 12 months of their lives. The clinician was unable to tell us how many patients this affected. The practice did not have a palliative care register and the lead clinician was unaware how to access patient records and had to ask the administrative staff for guidance.
- We found the lead GP provided a lack of clarity about the patient referral process to ensure appointments were made and followed up where required.

The practice's uptake for the cervical screening programme was 75%, which was below the CCG average of 78% and the national average of 81%. The exception reporting rate was 13%. The administrative staff took a lead role in booking and following up any issues for the locum staff; none of these tasks were clinician lead or supported. We identified three un-actioned test results, one dated back to October 2016 and two other results that had not been actioned from March 2017.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Fabric curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could not be treated at the practice by a female clinician.

We received 25 comment cards with mixed comments about the practice. Several cards commented on the kindness of the staff. One card commented on the kindness of one of the regular locum doctors. Another card felt they had poor access to regular and emergency appointments. One negative comment card stated they received a poor service and that doctors were rude, did not give them the required time to explain a test result and became impatient with them. Another card stated that they had problems with their prescriptions regularly being mixed up and that there was a constant change of GPs and nursing staff, which they felt was poor and did not provide continuity.

We spoke with one patient during the inspection. They were happy with the care they received and thought that staff were caring, however they did not attend the practice on a regular basis.

Results from the national GP patient survey showed the practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) average of 90% and the national average of 92%.
- 68% of patients said the GP was good at listening to them compared to the CCG average of 87% and the national average of 89%.
- 70% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 66% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 86%.
- 83% of patients said the nurse was good at listening to them compared with the CCG average of 90% and the national average of 91%.
- 91% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 91%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 91%.
- 76% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 89%.

Care planning and involvement in decisions about care and treatment

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

- 68% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 89%.
- 62% say the last GP they saw or spoke to was good at involving them in decisions about their care compared to the clinical commissioning group (CCG) average of 79% and the national average of 82%.
- 83% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Inadequate

Are services caring?

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

The practice had a carers folder and information file in the waiting area, however the practice had identified no patients as carers. Appropriate support could therefore not be provided.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice did not review the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice was part of the North Manchester Integrated Neighbourhood Care Team (NMINC) which was about working together to support patients who had health or social care problems/concerns/difficulties and would benefit from a multidisciplinary approach to health and social care delivery.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were disabled facilities and a hearing loop available.
- There was a website and online services for patients.
- The practice was also part of GP access scheme offering extended hours and weekend appointments to patients. In conjunction with other practices it offered extended opening times for patients.

Access to the service

The practice was open from 8am until 6.30pm Monday, Tuesday, Thursday and Friday and Wednesday 8am until1pm. Appointment times were Monday 9am until 11.50am and 4pm until 6pm. On Tuesday, Thursday and Friday they were 9am until 11.30am and 4pm until 6pm. On Wednesday they were 8.50am until11.20am due to the practice being closed in the afternoon. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

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

- 72% of patients said their last appointment was convenient, compared with the clinical commissioning group (CCG) average of 89% and the national average of 92%.
- 35% of patients said they could get through easily to the practice by phone compared with the CCG average of 71% and the national average of 73%.
- 77% of patients said that they were able to get an appointment to see or speak to someone the last time they tried compared with the CCG average of 80% and the national average of 85%.
- 46% of patients described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.
- 47% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 50% and the national average of 58%.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns.

- There was a newly designated responsible person who handled all complaints in the practice. This role was appointed to the day prior to the inspection. No training was offered or guidance provided on how to manage the process. The practice did have a standard form and a complaint leaflet that could be shared with patients.
- We found that complaints were not investigated and patients did not receive a response from the practice. We reviewed two separate complaints which had been escalated by the patients to NHS England (NHSE), as they had not received a written response from the practice. This resulted in the NHSE writing to the practice to ask them to respond. The practice did reply to NHSE.
- Lessons were not documented or learned from individual concerns and complaints with no documentation of analysis of trends or action taken as a result to improve the quality of care.

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 no documented vision or strategy for the future and staff were unaware of the vision and values for the practice. When we spoke to the administration staff they all indicated they strived to deliver the best care and service to patients.

Governance arrangements

The arrangements for governance and performance management did not operate effectively.

Following the inspection evidence was submitted by the provider at the request of the Commission to confirm that urgent action was being taken regarding the more significant concerns identified. The majority of these immediate risks were delegated to administrative staff to action. Overall there appeared to be a limited presence of the provider and lead GP.

The practice did not have an overarching governance framework which supported the delivery of good quality care:

- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effectively managed. For example, the practice had not established an effective process to monitor the most vulnerable patients in the practice. The lead clinician was unaware of the processes locum clinicians followed.
- An understanding of the performance of the practice was not maintained. The practice did not establish an effective programme of regular clinical audits to assess, monitor or improve the quality and safety of the services provided. For example, clinicians were unable to provide documentation to support the completion of clinical audits. The lead clinician was unable to access quality and outcome framework (QOF) data or chronic disease registers without help from the administrative team.
- The practice administrative staff were trying to fill the nurse and practice manager vacancies in the practice. However, we saw that nurse related tasks had not been completed. For example, there was no infection control process in place. The storage and monitoring of vaccinations and medicines were not effectively managed.
- The process to monitor whether relevant nationally recognised guidance was being followed had not been established. We saw that high-risk medicines, which required closer monitoring, were not being monitored appropriately. There were areas where care plans had not been completed.
- There was a staffing structure in place and staff were aware of their own roles and responsibilities. The lead clinician however did not involve themselves in the formulation and embedding of renewing or updating protocols in order to provide support and input to improve services for patients.
- Some practice specific policies were implemented and were available to all staff. However, some of these had not been updated or reviewed since the previous practice manager had left in 2016. For example, when we asked staff about the practice's business continuity plan they were not aware of this policy or what to do in an emergency situation.
- We found complaints that were not investigated appropriately and had not been reviewed to show whether learning had occurred or practice changed as a result of any action taken.
- We did not see a clear process to monitor which staff had undertaken training, for example not all relevant staff had received training on infection control or safeguarding. The lead GP was only trained to a level two in safeguarding children, and not the required minimum of a level three.
- The practice used an external company to manage human resources (HR) issues.

Leadership and culture

The practice did not have the clear clinical leadership or support from the lead GP, this was reflected on the whole practice's minimal systems and processes that should ensure safety and high quality care. The lead GP was not visible in the practice on a daily basis. The practice did not meet the requirements of the Health and Social Care Act. There were multiple issues and serious concerns identified that threatened the delivery of safe and effective care, which the practice had not identified or adequately managed.

Are services well-led?

Inadequate

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

Staff told us they did not feel listened to, they felt under extreme pressure and not supported on a daily basis. We were told by the staff they felt there was no structure and found things difficult, such as covering staff holidays, due to the extra work load placed on them. The two senior staff members worked part time and were solely responsible for the entire practice and the day to day running of the practice. For example, we were told the administrative staff had to seek help from another practice manager to enable them to pay their salaries. When the previous practice manager left the practice, this task was not shown to any of the existing staff, resulting in all administrative staff not being paid on time.

The lead GP was aware of but did not have systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).The lead GP did not provide support or training for staff on the process to communicate with patients about notifiable safety incidents or held any clinical meetings to discuss with any locum staff.

- The practice did not provide people reasonable support, truthful information and a verbal and written apology.
- The practice did not keep written records of verbal interactions or written correspondence.

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

There was no patient participation group (PPG) at the practice.

The practice had minimal engagement with people who used the service, only relying on the national patient survey results. For example, one of those national results, the Friends and Family Test (FFT), showed no patients had submitted their feedback. The practice did have the monitor in the waiting room and had collected FFT data. We were told by the staff appointed to manage this data that they had not received any training, guidance or support on how to submit the data and therefore did not know what to do.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How this regulation was not being met:** • The provider did not provide personalised treatment and care plans were not in place to meet their patients individual needs or reflect their individual preferences. • The provider had no system in place to record or act on significant event or incidents. • The provider did not have relevant risk assessments or COSHH procedures in place. • The provider did not oversee the proper and safe management of medicines including emergency medicines, repeat medicines and vaccinations, with non-clinical staff being responsible. Emergency medicines and responses to emergencies were inadequate. • The provider did not have any processes for preventing, detecting and controlling the spread of, infections. • **The provider had not performed any clinical audit cycles.** • **The provider had a lack of clarity of the referral and appointment system.** **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The provider did not have systems and processes established and operated effectively to prevent abuse of service users.

The safeguarding lead was unaware how many patients were at risk and not trained to the appropriate level, and other members of the staff had expired. No patients had alerts on their clinical records.

This was in breach of regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The provider did not have an effective system in place to investigate and appropriately respond to all complaints made. This was in breach of regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider took no clinical accountability, leadership or support in the day to day running of the practice. They did not provide systems and processes to ensure compliance with the regulations.

This section is primarily information for the provider

Requirement notices

The provider had no system in place to monitor, assess and improve the quality of the service for staff or patients. They did not manage 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. For example:

- There were no vision or mission statement.
- Policies were out of date or did not reflect the practice.
- There was no process for medical alerts
- There was no clinical or non-clinical meetings taking place.
- Staff were performing duties outside their role with no support or guidance from the provider.
- There was no record of clinical locums' recruitment checks, registration with appropriate professional bodies and relevant infectious status were not recorded.
- There was no monitoring of staff training

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider did not ensure staff received appropriate support, training, professional development and supervision as necessary to enable them to carry out the duties they were employed to perform. This was in breach of regulation 18 (2) 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.