

Dr NHR Simpson's Practice

Quality Report

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Date of inspection visit: 24 June 2015

Date of publication: 01/10/2015

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

Ratings

Overall rating for this service

Inadequate



Are services safe?

Inadequate



Are services effective?

Inadequate



Are services caring?

Requires improvement



Are services responsive to people's needs?

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 Dr NHR Simpson's Practice on 24 June 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate in providing safe, effective, responsive and well-led services and requiring improvement for providing caring services. It was also inadequate in providing services for all the population groups.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe, for example, appropriate recruitment and accreditation checks.
- There was no evidence of any induction process for nursing and HCA (Health Care Assistant) staff.

- Staff were clear about reporting incidents, near misses and concerns, however the investigation of such was not sufficient for learning and preventing re-occurrence.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example there was no evidence of practice protocols for the management of illnesses such as hypertension, diabetes, chronic kidney disease or asthma.
- Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring.
- Urgent appointments were usually available on the day they were requested. However patients said that it was difficult to get through by telephone.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- The business continuity plan was not personalised to the practice and had no contact details completed should an emergency arise.
- Multi-disciplinary team meetings were not in place to discuss vulnerable adults and children.

Summary of findings

- Medication checks were not being evidenced and there were no clear guidelines for staff to work from.
- The incoming mail including correspondence relating to patients was being prioritised by non-clinical administrative staff with no formal process or procedure to work to.
- There had not been an infection prevention control audit since 2012.

The areas where the provider must make improvements are:

Action the provider MUST take to improve:

- Address identified concerns with infection prevention and control practice.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies, protocols and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice including the Business continuity plan to be updated and personalised to the practice.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure that full investigations of serious incidents are undertaken and actions and lessons learned are taken to prevent reoccurrence. Also to demonstrate candour where necessary.
- Ensure that there is a process for incoming mail that is robust and clinically safe.

- Ensure recruitment arrangements include all necessary employment checks and staff are adequately trained to perform their roles, such as chaperone training and mental capacity training.
- Put systems in place to ensure medications are checked to ensure that drugs are safe and are within the manufacturers expiry dates.
- Update registration details for provider, partners and registered manager.

Action the provider SHOULD take to improve:

- Improve processes for making appointments.
- Ensure complaints and significant events are regularly discussed.
- Multi-disciplinary meetings should commence to discuss the safeguarding of vulnerable patients.
- Ensure there is a policy for the management of Legionella and undertake an assessment of the risk from Legionella.
- Process and policy to identify and monitor risks to patients, staff and visitors to the practice.
- Recall processes to be built and embedded in practice for the management of long term conditions.

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?

The practice is rated as inadequate for providing safe services and improvements must be made. Staff were clear about reporting incidents, near misses and concerns, however the practice did not carry out thorough investigations when things went wrong. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example incoming mail was prioritised by non clinical staff without a process for them to follow and there had not been an infection prevention audit since 2012 despite minor surgery been carried out on the premises each week.

Inadequate



Are services effective?

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average for the locality. Knowledge of and reference to national guidelines were inconsistent. There was a lack of evidence that audits were improving patient outcomes. Staff were not referring to guidance from the National Institute for Health and Care Excellence and there were no clinical protocols in place or followed in relation to management of conditions such as hypertension, diabetes, chronic kidney disease or asthma. There was evidence of appraisals and personal development plans for all administrative staff but only two out of eight clinical staff. Staff worked with multidisciplinary teams in relation to palliative care however there was no formal meetings in place to discuss vulnerable adults or children's safeguarding.

Inadequate



Are services caring?

The practice is rated as requires improvement for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they felt the practice offered an excellent service and staff were mostly efficient, helpful and caring however some comments were less positive in relation to been unable to get an appointment. Patients we spoke with on the day of the inspection said there were concerns in relation to the reception staff.

Information for patients about the services available was easy to understand and accessible

Requires improvement



Are services responsive to people's needs?

The practice is rated as inadequate for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements

Inadequate



Summary of findings

for all of the areas identified. Feedback from patients had reported that access to appointments had been difficult and a named GP and continuity of care was not always available quickly. The practice was equipped to treat patients and meet their needs but were heavily reliant on locum support due to difficulties with recruitment of permanent salaried doctors. Patients could get information about how to complain in a format they could understand. Complaints were received but were responded to verbally and there was no evidence of these responses nor any evidence that learning from complaints had been shared with staff.

Are services well-led?

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. Due to recent changes in the partnership staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure however staff said that in the last month the practice had improved and was working together. The practice had a number of policies and procedures to govern activity, but these were over three years old and had not been reviewed since. Not all of the policies were personalised to the practice. Some of them had identified leads that had left the practice, one of them over 14 months before. The practice had recently started to hold regular practice meetings however governance issues including complaints, significant events and patient safety alerts were not standing agenda items.

Inadequate



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

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

Care and treatment of older people did not always reflect current evidence-based practice. The practice used the Quality and Outcomes Framework to measure its performance. QOF data showed that outcomes for patients for conditions commonly found in older people were below CCG and national averages. For example, heart failure was 68.1% with CCG average at 96.9% and national average of 97.1%, dementia was 19.2% with CCG average of 92.3% and national average of 93.4% whereas chronic obstructive pulmonary disease was 91.4% with CCG average of 95.9% and national average of 95.2%. Longer appointments and home visits were available for older people when needed. Services for older people were reactive, and there was a limited attempt to engage this patient group to improve the service.

Inadequate



People with long term conditions

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

Nursing staff had lead roles in some chronic disease management however there was no process for recalls. Not all these patients had a structured annual review to check that their health and care needs were being met. Longer appointments and home visits were available when needed.

Inadequate



Families, children and young people

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

There were no systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates for the standard childhood immunisations were

Inadequate



Summary of findings

in line with CCG average. Appointments were available outside of school hours and the premises were suitable for families, children and young people because they were spacious with room for pushchairs, easily accessible with parking available.

Working age people (including those recently retired and students)

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. The practice had online appointments that could be booked and had extended hours on a Tuesday and Wednesday from 7am to 8am.

Inadequate



People whose circumstances may make them vulnerable

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

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Longer appointments for those patients who needed them were available. It had carried out annual health checks for people with a learning disability.

The practice had not worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Most staff knew how to recognise signs of abuse in vulnerable adults and children. Most staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Inadequate



People experiencing poor mental health (including people with dementia)

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

Inadequate



Summary of findings

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Only 56% of people experiencing poor mental health had received an annual physical health check. The practice did not work with multi-disciplinary teams in the case management of people experiencing poor mental health. It did however carry out advance care planning for patients with dementia. The practice had appointments available with a mental health nurse in the practice each week, however not all the staff were aware of this.

It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The January 2015 national GP patient survey sent out 263 surveys and the practice had a 42% return rate. It showed that 69% of patients would recommend the surgery to others. 79% of patients who responded described the overall experience as good. 85% of respondents felt the GP treated them with care and concern (above CCG and national average) and 94% of respondents felt the nurse treated them with care and concern. 55% of respondents said that they found it easy to get through to this surgery on the phone (below CCG and national average).

We spoke with 13 patients on the day of our visit. Patients identified that they had issues with getting through on the phone. One patient told us they had waited on the phone for thirty minutes or more to get an appointment only to be cut off. Another patient told us they had found the telephone system not too bad and not had any real problems apart from a short wait. However all thirteen were generally positive about the care and support they received at the practice.

We reviewed 25 comments cards that had been completed and left in a CQC comments box. The

comment cards enabled patients to express their views on the care and treatment received. 16 out of the 25 cards completed had positive comments on them. They all felt that the quality of care was good. They felt respected, well looked after and staff were kind and helpful. Eight were positive but with negative comments around relating to the time it takes to get through by telephone, not seeing the same GP, and difficulty to get convenient appointments. We spoke with the management team who were aware of the on-going issues.

We met with the chairperson of the patient reference participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. They said that the meetings were well attended with the last meeting being attended by 40-50 people. They stressed that the PPG was not a forum for complaints but to help the practice improve. As a result of feedback from the PPG and other patients they had worked with the practice to get in an HR consultant to address issues with reception staff that had been highlighted.

Areas for improvement

Action the service **MUST** take to improve

- Address identified concerns with infection prevention and control practice.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies, protocols and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice including the Business continuity plan to be updated and personalised to the practice.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements

- Ensure that full investigations of serious incidents are undertaken and actions and lessons learned are taken to prevent reoccurrence. Also to demonstrate candour where necessary.
- Ensure that there is a process for incoming mail that is robust and clinically safe
- Ensure recruitment arrangements include all necessary employment checks and staff are adequately trained to perform their roles, such as chaperone training and mental capacity training.
- Put systems in place to ensure medications are checked to ensure that drugs are safe and are within the manufacturers expiry dates.
- Update registration details for provider, partners and registered manager.

Action the service **SHOULD** take to improve

- Improve processes for making appointments.

Summary of findings

- Ensure complaints and significant events are regularly discussed
- Multi-disciplinary meetings should commence to discuss the safeguarding of vulnerable patients.
- Ensure there is a policy for the management of Legionella and undertake an assessment of the risk from Legionella.
- Process and policy to identify and monitor risks to patients, staff and visitors to the practice.
- Recall processes to be built and embedded in practice for the management of long term conditions

Dr NHR Simpson's Practice

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 advisor, a second CQC inspector, a practice nurse specialist advisor and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr NHR Simpson's Practice

Dr NHR Simpson's Practice is located at Barrow Health Centre, Barrow-Up-on-Soar, Loughborough, covered by NHS West Leicestershire Clinical Commissioning Group (CCG). The practice provides primary medical services to the area of Barrow-upon-Soar in Loughborough. The practice had a General Medical Service contract (GMS) and serves 8,695 patients. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice has four registered GP partners but is currently operated by only two GP partners (one male and one female), one salaried GP and one locum GP. The practice has a practice manager, a practice secretary, a data input manager and seven reception staff. There is also one health care assistant, three specialist nurses, one minor illness nurse, one diabetes nurse and two phlebotomists.

Dr NHR Simpson's Practice is a single-level practice, with access for disabled patients and car parking facilities. The practice is open 8.00am to 6.00pm Monday, Tuesday, Wednesday and Friday, closing for lunch 12.30pm to

1.30pm. On Thursdays the practice is open 8am to 12.30pm. The practice offers an extended hours service with pre-booked appointments on Tuesday and Wednesday mornings between 7.00am and 8.00am.

Dr NHR Simpson's Practice has opted out of providing out-of-hours services (OOH) to their own patients. Out-of-Hours services are provided through Leicester, Leicestershire and Rutland Out-of-Hours Service, which is provided by Central Nottinghamshire Clinical Services which patients access via the NHS 111 service.

We spoke with the management team with regard to their registration certificate. The Registered Manager was no longer at the practice however they were still registered with the CQC. The partners that were listed had also changed however the CQC had not been informed.

Why we carried out this inspection

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

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.

The practice had not previously been inspected by CQC.

Detailed findings

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

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

We carried out an announced visit on 24 June 2015. During our visit we spoke with a range of staff and GPs and spoke with patients who used the service. We talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice had four registered GP partners however only two were currently working at the practice (one male and one female), one salaried GP and one locum GP.

Practice meetings had commenced in May 2015 however the minutes that we saw for this meeting did not have set agenda items such as complaints and significant events and therefore the practice was unable to demonstrate a safe track record over the long term. The records we looked at which related to significant events, near misses and complaints showed that issues had been considered. However, they had not always been reviewed or investigated in enough depth to ensure that relevant learning and improvement could take place.

We also reviewed safety records, incident reports and complaints and found little evidence that these had been managed consistently over time.

The practice was unable to demonstrate a process for managing and disseminating safety alerts and the practice manager was unable to tell us where they came from or who they went to.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording of significant events, incidents and accidents however the monitoring and investigation of such was not sufficient for learning and preventing re-occurrence. We reviewed records of 11 significant events that had occurred during the last year and saw the system was followed appropriately for recording and reporting. Significant events had not been a standing item on the two practice meeting agendas we reviewed and there had been no dedicated meeting held to review actions from past significant events and complaints. There was no evidence that the practice had learned from these nor that the findings were shared with relevant staff.

Staff used incident forms on the shared drive and sent completed forms to the practice manager. However there were two incidents that had been completed - one on 28 May 2015 and one on 10 June 2015 - but the staff we spoke with were unaware when these would be reviewed or how. One serious incident involved a fridge used to store vaccines having been left open for a weekend which required the vaccines to be destroyed. There was no

evidence of staff interviews nor lessons learned from the incident. There had not been any documented meeting in relation to this incident. The action following the serious incident review was 'End of day routine check', the person responsible was 'admin' and there was no date for the action to be completed by. At the time of our visit there was no 'end of day routine' written process in place nor documentation to show that this was now part of an end of day process or that it had been actioned.

National patient safety alerts were not disseminated to practice staff. Staff we spoke with were unable to give examples of recent alerts that were relevant to the care they were responsible for. A GP we spoke with said that they received the safety alerts however there was no process for sharing with the rest of the team. The policy for patient safety alerts stated that they were received into practice and one copy was filed in a binder. This process was not followed in the practice and the practice manager was unaware of the policy and what it stated. We spoke with other staff in the practice who were unaware of any recent safety alerts or what safety alerts were.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records of six staff members which showed that only two had received relevant role specific training on safeguarding. Staff that we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients

Are services safe?

attended appointments; for example children subject to child protection plans. There had not been any meetings in relation to safeguarding vulnerable patients. There was an up to date process and policy.

There was a chaperone policy, and signs for patients to request a chaperone which were visible on the waiting room noticeboard, in consulting rooms and on the practice website. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception staff would act as a chaperone if nursing staff were not available, however they had not had chaperone training. All staff, including administrative staff, undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

A significant event had been recorded on 2 April 2015 which highlighted communication from a consultant cardiologist had not been actioned as incoming mail was prioritised by non-clinical staff and they had missed the letter. The action relating to the incoming mail reception process stated that staff should not have missed it, however the process had not been changed accordingly to prevent reoccurrence.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice did not have a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We saw there was a process in place to monitor the fridge temperature daily to ensure they were operating in line with guidance on vaccine storage. We found that the monitoring system monitored and recorded the minimum and maximum temperatures and the thermometer was reset after the temperature was recorded. There had been two occurrences recorded where the temperature was out of range however no action had been taken. The nurse was unaware of the process or what had been done.

There were no processes in place to check medicines were within their expiry date and suitable for use. Two ampoules of Adrenaline were found to be out of date. Expired and

unwanted medicines were not disposed of in line with waste regulations. Following an incident that had left vaccines not fit for use, we were told that they had been disposed of incorrectly in a sharps bin.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Learning from incidents was not thorough nor discussed as a wider team to look at ways and develop systems to prevent reoccurrence and similar errors occurring again.

The practice did not have a process nor did they record when patients had collected their prescriptions. This meant that if a prescription went missing the practice could not identify if it had been collected.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had regular minor surgery sessions operating each week. There had not been an infection prevention control audit since 2012 and the policy that was dated 2012 stated responsible persons as a GP Partner who was not currently working at the practice and a practice manager that had left 14 months previously. We were told that one of the nurses was now the lead for infection control although when we spoke with that staff member they were unaware of this.

There was a policy for needle stick injury that was dated 2012 and had not been reviewed.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We did not see records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patient or that the practice had undertaken a risk assessment for legionella.

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. We looked at four clinical staff and three did not contain any references. One staff member did not have any record of their registration with the Nursing and Midwifery Council.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice relied heavily on locum GPs and nursing staff from agencies but we saw no evidence of quality assurance in relation to these staff. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice did not have systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There were no regular checks of the building or the environment.

There were no risk assessments in place and therefore risks had not been assessed, rated and mitigating actions put in place to reduce and manage any risks. The practice did not have identified risks on a risk log.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that some staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment however there were no records to confirm that it was tested regularly nor that there were regular checks that the pads used were within their expiry date.

Emergency medicines were accessible to staff in a secure area of the practice and all staff knew of their location. The emergency bag included medicines that may be required in a medical emergency however there was no check list of the available stock and expiry dates. A flow chart was kept in a folder for dealing with emergencies was kept in a folder however the staff we spoke with were unaware of this and it was unclear what reception staff would do. Although the defibrillator was behind the reception area, the reception staff that we spoke with were confused about the location of oxygen and emergency drugs. The staff member we spoke with said that they would just call 999.

Processes were not in place to check whether emergency medicines were within their expiry date and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. However the document had not been personalised to the practice and did not contain relevant contact details for staff to refer to. The plan was not dated and therefore it was not clear if and when it was due to be reviewed.

Records showed that staff were not up to date with fire training having only found evidence of one staff member that had completed this.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with the GPs and there was no system in place for reviewing new/amended guidelines in relation to The National Institute for Health and Care Excellence (NICE) Guidance in the practice. The practice manager was unaware of how NICE Guidance was received into the practice. The policy for NICE Guidance stated that they were received into practice and one copy was saved on the shared drive. However the NICE folder on the shared drive only contained one NICE update from 2012.

The GPs told us they had nurses to lead in specialist clinical areas such as diabetes and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. There was no evidence of practice protocols to instruct and guide staff in the management of illnesses such as hypertension, diabetes, chronic kidney disease or asthma. We asked if there were any protocols in place and the GPs we spoke with said that they were not.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us four clinical audits that had been undertaken in the last two years. Two of the audits we reviewed were led by the prescribing lead from the CCG. These were good quality audits that had external review by the medicines optimisation team. They clearly showed two cycles of audit, the second audit showed an improvement in standards.

The practice also used the information collected for the QOF and performance against national screening

programmes to monitor outcomes for patients. This practice was an outlier for various QOF clinical targets. It achieved 78.8% of the total QOF target in 2014, which was below the national average of 93.5%. Specific examples to demonstrate this included:

- Performance for asthma related indicators was 39.7% compared with 97.1% which was the CCG average and the national average of 97.2%.
- Performance for mental health related QOF indicators was 69.7% compared with the CCG average of 94.4% and the national average of 90.4%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 23.1% which was below the CCG average of 83.3% and below national average of 83.8%.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The team was not making use of clinical audit tools and staff meetings to assess the performance of clinical staff. There was no evidence of clinical meetings taking place and the practice meetings that had been held did not have clinical audits minuted nor were they a standing agenda item.

The practice's prescribing rates were similar to national and locality figures.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice displayed a list of end of life patients for staff to view at a glance which enabled reception staff to be aware and care to be given accordingly.

Staff were unable to describe recalls and processes in place in relation to long term conditions. The CCG had identified issues in relation to coding errors and the practice had employed a data input manager who had started work on the coding and working towards having recall processes and procedures in place. This was currently done on an adhoc basis due to staff turnover with the nursing staff at the beginning of 2015.

Are services effective?

(for example, treatment is effective)

Where annual reviews were undertaken for people with long term conditions (e.g. diabetes, chronic obstructive pulmonary disease, heart failure), these were structured. However due to staff turnover and inability to recruit, the reviews of these patients had not been monitored and patients were not recalled. The practice had recently employed a staff member to work alongside nursing staff to develop procedures and policies for recalls and also to look at coding issues within the practice.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were below other practices in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers' list with NHS England).

All administrative staff had undertaken annual appraisals that identified learning needs from which action plans were documented. The practice manager and the partners were aware of the issues around the lack of training and had signed up to online training however this had not yet commenced. The practice could not evidence that any of the identified gaps in staff training had been completed.

There was no evidence of any induction process for nursing and HCA (Health Care Assistant) staff. We looked at the files of seven members of staff and found that one of these staff had completed Fire Safety training, two had completed Safeguarding Adults and Children training and five had completed Basic Life Support. There was no health check information for two of the four clinical staff. Of the four clinical staff files we looked at three did not contain any references. One nurse did not have any record of their registration with the Nursing and Midwifery Council

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

However, the incoming mail including correspondence relating to patients was being prioritised by non-clinical administrative staff with no formal process or procedure to work too. The correspondence had not been dated as received. These staff were making decisions as to whether incoming mail of a medical nature needed to be seen by a clinician or not. The staff we spoke with who were responsible for this process told us they had not received any training nor were there any protocols or written process that they were aware of.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses, community heart failure nurse, diabetes and respiratory nurses and the lead nurse for the virtual ward and LOROS nurses (LOROS is the local charity that provides support for people and families that are palliative). At these meetings decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Emergency hospital admission rates for the practice were lower at 9.15% compared to the national average of 13.6%.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

Special patient notes were used and information was able to be added to the system to enable other teams to have necessary information to be shared. Care plans were created on the system and special notes were uploaded.

Are services effective?

(for example, treatment is effective)

This allows end of life care and DNACPR (do not attempt cardiopulmonary resuscitation) information to be accessed by other teams. We were able to look at examples of this and found this system to be working very well.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were not aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The nursing staff we spoke with were not aware of the key parts of the legislation.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice if necessary following

a review by the GP. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 15% of patients in this age group took up the offer of the health check.

The practice's performance for the cervical screening programme was 86.98%, which was above the national average of 81.89%. The nurse that carried out cervical screening that we spoke with was unaware of written guidance on follow ups of cervical screening and where unsure who did the recalls.

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

- Flu vaccination rates for the over 65s were 72.27%, and at risk groups 38.76%. These were below national averages of 73.24% and 52.9% respectively.

Childhood immunisation rates for the vaccinations given to under twos ranged from 95.9% to 100% and five year olds from 94.1% to 99%. These were comparable to CCG averages.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey of January 2015.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was also in line with CCG and national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% of respondents to the GP patient survey said the GP was good at listening to them compared to the CCG and national average of 89%.
- 87% of respondents to the GP patient survey said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 97% of respondents to the GP patient survey said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Seven comments were less positive mainly in relation to been unable to get an appointment but the majority felt that the practice had improved over the last month. We also spoke with 13 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice however there were concerns in relation to the reception staff however they felt this had improved recently.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located at the back of the reception desk. There was a sign encouraging patients to stand back from reception desk to maintain confidentiality. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 72% of respondents to the GP patient survey said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 83% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.
- 74% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 82%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive they felt the doctors that they saw were very caring and understanding. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 85% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 94% 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 90%.

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

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that there was no bereavement process in place however they would always be available if the bereaved family needed an appointment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The partners currently working in the practice were in the process of looking at the needs of the practice population and putting systems in place to address the identified needs in the way services were delivered. However we were aware that there had been pressure on services due to recent changes in clinical staff which had impacted on the level of service provided to the patients, for example longer wait for appointments and not seeing the doctor of their choice.

The NHS England Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw an action plan from an appraisal with the CCG from 2014/2015. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

Access to the service

The surgery was open 8.00am to 6.00pm Monday, Tuesday, Wednesday and Friday. The practice closed for lunch 12.30pm to 1.30pm on these days. On Thursdays the practice was open from 8am to 12.30pm. Appointments were available during the opening times of the practice. In addition the practice offered extended hours with pre-booked appointments on Tuesday and Wednesday mornings between 7.00am and 8.00am. There were urgent appointments available each day with the duty doctor between 5.00pm and 6.00pm.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to one local care homes on a specific day each week, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice low in these areas. For example:

- 64% were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 76%.
- 64% described their experience of making an appointment as good compared to the CCG average of 75% and national average of 74%.
- 78% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 71% and national average of 65%.
- 55% said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 74%.

Are services responsive to people's needs?

(for example, to feedback?)

- 92% said that they were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 88% and the national average of 85%

Patients we spoke with were not satisfied with the appointments system and said that it was difficult to get through by telephone in a morning. Also after been on hold they had been cut off and that there was always a queue at the surgery in the morning. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking up to three months in advance. The practice told us that they were aware of problems with the current phone system that was in use and were actively working to end that contract and replace with a new system that would help alleviate the current issues.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in

line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. The policy and procedure in place stated that patients would receive acknowledgement within three working days and also that complainants would receive a written response. However this was not the case. Complaints were received but most complaints were responded to by telephone or face to face and there was no evidence of these responses.

We looked at 18 complaints received in the last 12 months and found that these had not been dealt with in a timely way or as per the practice policy. We saw little evidence of lessons learned and actions taken to reduce reoccurrence and as responses were mainly verbal there was little evidence that apologies were given where required.

The practice did not review complaints annually to detect themes or trends nor were they a standing item on a practice meeting.

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 did not have a clear vision to deliver high quality care and promote good outcomes for patients. The practice did not have a strategy and business plan for the future. The practice had four partners registered with the Care Quality Commission however one of the partners had left the partnership and the practice in 2014 and one of the other partners, who was the Registered Manager, was no longer working at the practice.

We spoke with four members of staff and they all felt that there had been improvements made at the practice in the previous four weeks and that they felt they were now working together. Practice meetings had recently restarted however no formalised agenda had been set as yet.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a folder. We looked at ten of these policies and procedures. There was a cover sheet to be signed by staff to confirm that they had read the policy. The cover sheets however had only been completed by one or two staff and were not dated. Eight of the ten policies and procedures we looked at were dated in 2012 and had not been reviewed annually. They were not up to date or personalised to the practice processes.

There was a leadership structure with named members of staff in lead roles. For example, the senior partner was the lead for safeguarding. The practice manager told us that the infection control lead was one of the nurses but the nurse was unaware of this when we asked them. Staff we spoke with all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The two partners currently working at the practice and the practice manager had not played an active role in overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The partner who had recently stopped working at the practice and an assistant practice manager who had left in January 2015 had been more involved in this. This included using the QOF to measure its performance. The QOF data for this practice showed it was not performing in line with national standards. QOF data was not regularly discussed at monthly team meetings and action plans were

not produced to maintain or improve outcomes. The low scores of QOF had been raised and this had been identified partly as a coding issue at the practice. The practice had recently recruited a data input manager to work on this.

The practice had not identified, recorded and managed risks.

The practice had recently introduced monthly staff meetings, however there was no standing agenda items where governance issues were discussed. We looked at minutes from these meetings and found them to be mainly around personnel changes in the practice.

The practice had a whistleblowing policy which was available to all staff in a folder however this had not been reviewed since 2012. Staff that we spoke with were aware of the policy.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff.

Staff felt that recently there had been improvements and that they were now working together.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients.

It had an active PPG (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). which meets every two months and has six to seven active members. They also had open meetings twice yearly and the last meeting was attended by 40-50 people. The PPG have had a stall on the village market and are engaged with health promotion and encouraging patients to come into surgery for long term conditions and healthy lifestyle advice. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing for example the practice told us that they were actively working to end the current telephone contract and replace with a new system that would help alleviate the current issues identified.

Are services well-led?

Inadequate 

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

The practice had not gathered feedback from staff other than appraisals which had only taken place for administrative staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

We looked at five clinical staff files and saw that regular appraisals had not taken place and therefore staff may not have had the opportunity to identify their needs and update and improve their knowledge and skills.

The practice had completed reviews of significant events however these had not been shared with staff at meetings nor had they been used to improve outcomes for patients. Actions that had been identified had not been put into place at the time of our visit. For example one of the complaints had an action of customer care training to be provided however at the time of our visit no date had been booked for this.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing The practice must ensure that appropriate support, training, professional development, supervision and appraisal takes place to enable staff to carry out the duties they perform and that this is recorded. Regulation 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the provider did not have an established, effective system to assess, monitor and improve the quality and safety of the services provided or assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1) (2) (a)(b)(c)(d)(i)(ii)(f) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were no protocols, policies or written guidance to support the staff who were non clinical. We found that significant events had been recorded; however we were unable to find evidence of investigations and there was no evidence of interviews of staff nor lessons learned from the incident. There had not been an infection prevention control audit since 2012. There was no system in place for reviewing new/ amended guidelines in relation to The National Institute for Health and Care Excellence (NICE) Guidance in the practice. There was no evidence of practice protocols for the management of illnesses such as hypertension, diabetes, CKD chronic kidney disease or asthma in the protocol folder.

This section is primarily information for the provider

Enforcement actions

Regulation 12(1), 12(2)(a)(b)(d)(g)(h)