Dr Khin Thanda

Quality Report

Avenham Health Centre
Avenham Lane
Preston
Lancashire
PR1 3RG
Tel: 01772 401931
Website: No practice website

Date of inspection visit: 7 December 2016
Date of publication: 16/03/2017

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 the practice of Dr Khin Thanda on 7 December 2016. Overall the practice is rated as Inadequate.

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

- There was a system in place for reporting and recording significant events.
- Risks to patients were assessed but steps to manage these risks were not always in place for example, in the care of patients with significant health problems.
- There was no gas safety certificate available for the building.
- The oxygen cylinder for use in an emergency was empty. The provider made arrangments immediately to have this replaced.
- Safeguarding processes within the practice were not embedded.
- There had been no recent audit on infection prevention and control; we found cleaning standards to be below those expected.
- There was limited evidence of clinical audit, learning from audit and of results being used to drive improvement.
- Latest available data showed that attendance of patients at accident and emergency units was high. The evidence provided by the practice on the day of inspection, and following the inspection did not demonstrate that the practice was working effectively to address this.
- Results from the Quality and Outcomes Framework (QOF) were below Clinical Commissioning Group (CCG) and national averages. There was no improvement plan in place to address this.
- Not all required recruitment checks were in place for all staff.
- Information about services and how to complain was not readily available. We found no formal complaints had been received for more than four years; verbal complaints were not recorded.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- Staff assessed patients' needs and delivered care in line with evidence based guidance.

Summary of findings

- Clinical staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. Administrative staff required training in areas such as infection control, and one staff member had not received training in safeguarding.
- There was a lack of leadership within the practice; there was no succession planning in place.
- There was no practice website available for patients to access information.
- We found evidence that access arrangements for patients between 6pm and 6.30pm were unsatisfactory. Calls to a mobile phone during this period had not been answered.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

The provider must put systems and processes in place to ensure care and treatment is provided in a safe way to service users, including:

- Assessing the risks to the health and safety of service users of receiving care or treatment;and
- Doing all that is reasonably practicable to mitigate such risks. This includes but is not limited to:
- Using and reviewing care plans and working effectively with community based clinicians to improve patient care;
- Learning from incidents involving patient care.
- Ensuring all emergency medicines including oxygen are available for use.
- Ensuring all cleaning systems and processes within the practice are correctly managed and maintained and that cleaning meets required standards.
- Ensuring that all staff receive training in infection control sufficient to support them in their role.

The provider must establish systems and processes which operate effectively that enable the registered person to:

- Assess, monitor and improve the quality of services through recognised quality improvement activity. This includes but is not limited to:
- Improving audit and using results to drive improvements in patient care.
- Implementing effective improvement activity to reduce the numbers of patients presenting at accident and emergency units.
- Use of effective improvement activity to increase patient satisfaction and sharing results with patients
- Ensuring the complaints process is accessible to all patients and keeping accurate records of all complaints.
- Reviewing safeguarding processes within the practice to ensure all staff understand their role and the administrative procedures that support the safeguarding responsibilities of the practice.
- Ensuring all safety governance checks are in place
- Ensure that all required recruitment checks are carried out and records of these are held.
- Ensure all staff training is delivered and records of this are up to date.

The areas where the provider should make improvements are:

- Develop a practice website to facilitate patients access to information.
- Invite the input of the locum GP on significant events, to improve learning outcomes.
- Schedule clinical meetings when the locum GP is able attend.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The 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

Summary of findings

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.

- There was a system in place for reporting and recording significant events. However the long term locum GP did not attend meetings where these were discussed.
- Leaders did not act on the findings of significant event analysis to improve patient care and safety.
- Safeguarding processes were not embedded at the practice; the practice manager did not know who the deputy lead on safeguarding was but thought it may be them.
- GPs did not provide reports for safeguarding review boards. Safeguarding wasnot routinely discussed at multi-disciplinary team meetings. A member of staff had not received training in child safeguarding.
- There was a poster advertising a chaperone service in the waiting area of the practice but the practice ability to provide this was limited as only the nurse was able to perform chaperone duties. This was ineffective for both patients and clinicians.
- Cleaning standards at the practice fell below those expected in a primary care setting. Effective checks on cleaning were not in place. There had been no recent infection prevention and control audit conducted at the practice. Staff had not received infection control training. Staff could not locate spill kits.
- The oxygen cylinder for use in emergencies was empty, and a record of checks on this equipment indicated that it was safe and ready for use. When we brought this to the attention of the practice steps were taken to replace the oxygen cylinder on the day of our inspection.
- Consistent water temperature checks were not being carried out as required. Paperwork from a contractor appointed to do this showed there was some remedial works required but this had not been carried out or progressed by the practice.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below average compared to the national average. QOF achievement overall was 81% of the points available, with an overall exception reporting rate of 12%.

Summary of findings

- Examples we reviewed showed that clinicians assessed needs and delivered care in line with current evidence based guidance.
- There was a lack of clinical audit to demonstrate quality improvement.
- Clinical staff had the skills, knowledge and experience to deliver effective care and treatment.
- Administrative staff did not have all the training they needed for their roles.
- There was no evidence of regular appraisals and personal development plans for all staff. We saw that three staff members had been appraised in 2016. There was no review of the work of the long term locum GP, who had been with the practice for six years and the last appraisal for the practice nurse had been in 2011.
- All required recruitment checks were not in place; clinicians provided details of their professional registration as well as enhanced background checks and medical negligence insurance cover on the day of inspection.
- Awareness and understanding of the Mental Capacity Act 2005, by the principal GP was limited.
- Systems for referrals of patients for further care whilst at home were not always followed through.

Are services caring?

Inadequate 

The practice is rated as inadequate for providing caring services.

- Data from the national GP patient survey showed patients rated the practice lower than others for several aspects of care.
- Patients were invited to give their opinion of the practice on Care Quality Commission comment cards, in the two week period before our inspection. We received two comment cards. One card recorded positive comments, which was completed by a staff member. The other card which was completed by a patient also gave positive comments.
- The practice held registers of patients who were carers, those with a learning disability and those who were classed as priority patients, for example those receiving palliative care.
- On the day of our inspection, we noted that staff spoke about patients in a derogatory manner and lacked empathy.
- Information for patients about services was available on patient notice boards.
- We saw staff maintained patient and information confidentiality.

Summary of findings

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice provides shared care to patients with substance misuse issues.
- The practice did not have a website and did not offer any extended hours service.
- The arrangements for patients to access the practice between 6pm and 6.30pm were not satisfactory. There was evidence that calls from patients to a mobile used during this period were not picked up.
- A&E attendances for patients from the practice were significantly high; for the period November 2015 to October 2016 1,193 patients attended the local accident and emergency units, which represents over 30% of the practice population.
- Feedback from the NHS England GP Patient survey showed patient satisfaction with the practice to be lower than CCG and England averages. The practice had no action plan in place to address this.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- Information about how to complain was not readily available. The practice told us they had not received any complaints for four to five years. Verbal complaints were not recorded.
- The practice had not been able to form a patient participation group.

Are services well-led?

Inadequate

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

- There was no succession planning in place, or a timetable for planned retirement of the principal GP.
- There was a leadership structure in place. The practice had policies and procedures to govern activity. However we noted that in several areas these were not followed, such as in infection control and recruitment.
- There was evidence which showed the skill mix at the practice was not being utilised to its best effect.
- Governance required improvement. The lack of cross checking processes within the practice meant that mistakes or errors were not identified.

Summary of findings

- There was a lack of systems in place aimed at driving improvement at the practice, for example, in terms of audits and review of performance month on month.
- The practice had systems in place for notifiable safety incidents. However we found the monthly MDT meeting was held at a time when the locum GP, who had been with the practice for six years, could not attend.
- The practice sought feedback from patients, for example, through surveys. However, the results did not drive any action plans to improve services for patients, for example, in access arrangements.
- There was no patient participation group for the practice; we were told steps had been taken to engage with patients to form a virtual group but patients could not commit to this.

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 ratings of inadequate for all key questions impact on all population groups.

- The practice had smaller numbers of older people making up the practice register, in comparison to other practices locally.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- We found that action points in respect of older patients discussed at multi-disciplinary team meetings were not always followed up, which impacted on the care of older patients.
- The practice ran a flu clinic each year to deliver flu vaccinations to older patients.
- The practice reviewed data to identify those patients at risk of hospital admission. However, we were unable to see any positive action taken by the practice that had made an impact on avoidable admissions.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The ratings of inadequate for all key questions impact on all population groups.

- The advanced nurse prescriber had a lead role in chronic disease management. The nurse had undertaken a significant amount of work in the case management of diabetes patients, delivering interventions to help improve the management of these patients' condition.
- Data from the Quality Outcomes Framework (QOF) showed practice results were in line with national averages for seven out of eleven of the diabetes care indicators. However we did note that only67% of patients with diabetes received an annual flu vaccination, which is seven percentage points below the CCG average and eight points below the national average.
- QOF scores in relation to patients with respiratory disease, such as chronic obstructive pulmonary disease (COPD) were lower than average in three of the six recorded outcomes for these patients. There was no action plan in place to address this.
- Longer appointments were available when needed.
- All these patients had a named GP.

Summary of findings

- For those patients with the most complex needs, the named GP told us they worked with health and care professionals to deliver a multidisciplinary package of care. However, we found some examples of care which fell below standards that patients should expect.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The ratings of inadequate for all key questions impact on all population groups.

- Safeguarding processes were not embedded at the practice.
- The practice manager did not know who the deputy lead on safeguarding was, but thought it may be them.
- GPs did not provide reports for safeguarding review boards. Safeguarding wasnot routinely discussed at multi-disciplinary team meetings.
- Some staff had not received training in child safeguarding.
- We did not see that the practice routinely followed up any attendance of young children at local accident and emergency units.
- Immunisation rates were relatively high for all standard childhood immunisations for children up to two years old. Some immunisation rates for children up to five years were lower than expected.
- Clinical staff demonstrated how children and young people were treated in an age-appropriate way and were recognised as individuals
- Rates of cytology screening (smear tests) were lower than expected. In the QOF performance year 2015-16, 50% of women eligible had received this intervention, which is 24 percentage points lower than the CCG average and 26 points below the national average. There was no action plan in place to address this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

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 ratings of inadequate for all key questions impact on all population groups.

- The practice offered continuity of care through the use of a long term locum GP who supported the principal GP.

Summary of findings

- The practice did not have a website but patients could access online services through the practice EMIS system, to book appointments and order repeat prescriptions. Patients with the appropriate secure access could also view their summary care record on the practice EMIS system.
- The practice could not demonstrate that access arrangements in place between 6pm and 6.30pm were sufficient to meet the needs of patients.
- There was no extended hours surgery available at the practice and no plans were in place to introduce this.
- QOF results in conditions common in working age people were below local and national averages. We also noted that rates of recorded prevalence were also low. This suggested that screening in place for these conditions was not effective.
- QOF results in relation to interventions in relation to patients who were smokers were significantly lower than local and national averages.

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 ratings of inadequate for all key questions impact on all population groups. However:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and those requiring more GP care such as palliative patients.
- The practice offered longer appointments for patients with a learning disability.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. We saw that carers were welcome to attend with patients if they required their support.
- Staff knew how to recognise signs of abuse in vulnerable adults. However, we did not see that safeguarding was embedded at the practice.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The ratings of inadequate for all key questions impact on all population groups.

- 67% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which

is significantly lower than the local (Clinical Commissioning Group – CCG) average of 86% and the national average of 84%. Exception reporting for this intervention was 25%, which is higher than the CCG average of 5% and national average of 7%.

- QOF data showed scores in relation to the care indicators for mental health patients were lower than CCG and national averages in all areas.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice maintained a register of patients experiencing poor mental health.

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 performing in below local and national averages in respect of 17 of the 22 questions put to patients. In the survey, 359 questionnaires were distributed and 76 were returned. This represented a response rate of 21%. The views expressed represent those of 2% of the practice's patient list.

- 63% of patients found it easy to get through to this practice by phone compared to the CG average of 74% and national average of 73%.
- 80% 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 78% and national average of 76%.
- 71% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and national average of 85%.
- 59% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 81% and national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received two comment cards. One was completed by a professional visiting the practice, who commented on the friendliness of the practice staff and the second commented that staff listened to what they as a patient had to say.

We were unable to speak with patients during the inspection as visitors to the practice on the day were limited.

Areas for improvement

Action the service MUST take to improve

The provider must put systems and processes in place to ensure care and treatment is provided in a safe way to service users, including:

- Assessing the risks to the health and safety of service users of receiving care or treatment;and
- Doing all that is reasonably practicable to mitigate such risks. This includes but is not limited to:
- Using and reviewing care plans and working effectively with community based clinicians to improve patient care;
- Learning from incidents involving patient care.
- Ensuring all emergency medicines including oxygen are available for use.
- Ensuring all cleaning systems and processes within the practice are correctly managed and maintained and that cleaning meets required standards.
- Ensuring that all staff receive training in infection control sufficient to support them in their role.

The provider must establish systems and processes which operate effectively that enable the registered person to:

- Assess, monitor and improve the quality of services through recognised quality improvement activity. This includes but is not limited to:
- Improving audit and using results to drive improvements in patient care.
- Implementing effective improvement activity to reduce the numbers of patients presenting at accident and emergency units.
- Use of effective improvement activity to increase patient satisfaction and sharing results with patients
- Ensuring the complaints process is accessible to all patients and keeping accurate records of all complaints.

Summary of findings

- Reviewing safeguarding processes within the practice to ensure all staff understand their role and the administrative procedures that support the safeguarding responsibilities of the practice.
- Ensuring all safety governance checks are in place
- Ensure that all required recruitment checks are carried out and records of these are held.
- Ensure all staff training is delivered and records of this are up to date.

Action the service SHOULD take to improve

The areas where the provider should make improvements are:

- Develop a practice website to facilitate patients access to information.
- Invite the input of the locum GP on significant events, to improve learning outcomes.
- Schedule clinical meetings when the locum GP is able attend.

Dr Khin Thanda

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 Dr Khin Thanda

Dr Khin Thanda's practice is a single handed GP practice and is based in a purpose built facility g which also accommodates a community health centre in Preston, Lancashire. The practice has approximately 3,200 patients and is part of Greater Preston Clinical Commissioning Group. The practice has experienced a rise in patients of approximately 3% annually in recent years. All services are delivered under a General Medical Services (GMS) contract.

Dr Khin Thanda is supported by a long term locum GP who has been with the practice for six years. The GPs work 2.5 days each and are supported by an advanced nurse prescriber (ANP) who works for 20 hours each week. The practice has three administrative and reception staff who are led by the practice manager. The practice is located in an area of high social deprivation.

The practice has car parking immediately outside the building, with clearly marked disabled spaces. There are accessible toilets in the community health centre which patients visiting the practice can access. All patient facilities are located at ground floor level. The practice had a reception and waiting area, two GP consulting rooms and a nurse treatment room. The rest of the space in the practice is made up of administrative and staff rest areas.

The practice contractual and advertised opening hours are from 8am to 6.30pm, Monday to Friday. However, the practice closes each day at 6pm and calls to the practice are diverted to a mobile phone. The practice stated that the mobile phone is manned and patients can book appointments when calling after 6pm. The practice does not provide any extended hours access. When the practice is closed (after 6.30pm) calls are diverted to NHS111, who can refer patients who require GP services, to the locally appointed out of hours service, Go to Doc.

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 to share what they knew. We carried out an announced visit on 7 December 2016. During our visit we:

- Spoke with a range of staff including a receptionist, the practice manager, the practice nurse and two GPs.
- We observed how staff interacted with patients who were waiting for appointments.

Detailed findings

- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people 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 a system in place for reporting and recording significant events.

- Significant events we reviewed were completed by clinicians. We saw they were recorded in detail. From the evidence presented the practice experienced three significant events in a period of 12 months. The incident recording form supported the recording of notifiable incidents under 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).
- From information made available to us at inspection, when things went wrong with care and treatment, we saw patients were informed of the incident, received reasonable support and information about their care and treatment.
- The practice carried out an analysis of the significant events but we did not see evidence that findings were used effectively to improve patient care as a result. We also found that significant events were not reviewed annually to enable clinicians to look for trends, or to check that any improvements put in place had been adopted and embedded.
- We noted that significant events were not routinely discussed at multi-disciplinary team meetings, which is the one full clinical meeting each month. The locum GP was not present at these meetings so was limited in their contribution to discussions on any of the subject agenda items.

We reviewed patient safety alerts. In the case of alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts, we saw that the locum GP and the principal GP managed these independently. The principal GP shared the alerts with the Advanced Nurse Prescriber (ANP). The principal GP worked with the medicines management team to conduct any reviews of patients medicines when required by an alert. There was evidence that action was taken to improve safety in the practice by reviewing alerts received in the past 12 months.

Overview of safety systems and processes

The practice had systems in place to keep patients safe and safeguarded from abuse, which included a named lead for child and adult safeguarding. When we asked about arrangements in place when the principal GP was away from work, we were told by the practice manager that they thought they were the safeguarding deputy lead. It was not confirmed at our inspection who the deputy lead on safeguarding was. We checked the practice safeguarding policy and saw that this was a generic policy with blank spaces for names, which had not been entered. The practice manager had been trained to safeguarding level one. The practice had not submitted reports for use at safeguarding review boards, when requested to do so. When we made checks on this we were told a summary care record would be given to the Health Visitor attending these meetings, however, there was no record of this on any of the practice systems. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. GPs were trained to child protection or child safeguarding level three.

When the principal GP was interviewed by Inspectors, they were unable to say how many children were on the practice safeguarding register. There was no evidence that the principal GP, who was the safeguarding lead, or the practice manager who was the deputy lead for safeguarding, systematically reviewed the safeguarding register to ensure it remains up to date. Safeguarding information including contact phone numbers were displayed in the staff kitchen area, behind the main reception desk. There were no telephone contact numbers for safeguarding professionals in the principal GPs consulting room. From minutes of multi-disciplinary meetings that we reviewed, we saw that health visitors did not routinely attend these meetings to discuss and review vulnerable patients and safeguarding concerns.

A notice in the waiting room advised patients that chaperones were available if required. The ANP acted as a chaperone and was 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). As the nurse worked part time we were told the patient would be asked to re-book their appointment at a time when the GP and nurse were available.

Inadequate

Are services safe?

The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place. However, the practice could not demonstrate that staff had received infection control training. We also noted that there was no infection control training listed as part of the induction process for new staff.

The practice manager told us they were responsible for carrying out cleaning checks. The practice employed a cleaner that carried out cleaning duties twice each week. Records of cleaning checks had only been kept since October 2016. Window blinds were dirty and there was dust on curtain rails in clinical rooms. When we reviewed the cleaning schedule for the practice, we saw that the nurses room and consulting rooms were listed to be cleaned "every time", and reference was made to dusting curtain rails.

When we looked at the cleaning cupboard and cleaning materials we found equipment was not labelled for use in specific areas within the practice. There was also a strong odour of foul water; the practice manager told us that this was from a mop that had been disposed of the previous day. There was no evidence of annual infection control audits, with the last annual audit having been performed approximately four years ago. The practice manager showed us an Infection Control Quality Improvement Tool, which they had asked the infection control lead at the CCG to provide. We saw that work to complete this had started on 1 December 2016. The practice manager failed to demonstrate that they had the required knowledge to inform them of standards of cleaning required within a primary care setting.

The practice manager advised that spill kits were kept in a cleaning cupboard within the community health area of the building. However, the practice manager was unable to find the kits in the cupboard. Staff working in the reception area did not know where the spill kits were located. The part time ANP kept a separate spill kit in their treatment room but staff were unaware of this.

Other arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal were adequate.

Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. This nurse received mentorship and support from the medical staff for this extended role.

We reviewed checks in place on water safety and Legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

We found undated records which showed two thermal valves required servicing. There was no record of this work being requested. When we asked staff about this they were unable to tell us what steps they took to address this matter.

We saw evidence of electrical safety checks for the building and for appliances and equipment. However, there was no record of a gas safety certificate. In the folder for buildings checks used by the practice there was a section labelled 'Gas safety report' but no report available.

We reviewed recruitment records held by the practice. There was no record of DBS checks held by practice on the ANP and the long term locum GP. The practice held no copies of medical indemnity insurance for either the locum GP, ANP or the principal GP. All these had to be collected from other work places or the homes of the clinical staff on the request of the inspection team. The practice manager had recently undergone a DBS check (September 2016) but had not been subject to this check prior to this. We were shown an invoice for a number of new DBS checks for all staff at the practice, dated 6 December 2016, which was the day before the inspection.

The practice did not hold evidence of the nurse's professional registration. This was printed out on the day of inspection by the nurse as the practice manager was unable to access evidence of registration. There was no evidence of GMC checks performed in relation to either the principal GP or the locum GP. All staff files we checked did not hold all recruitment checks as required by the regulations.

Inadequate

Are services safe?

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

We reviewed arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice is advertised as opening between 8am and 6.30pm. However, the practice building closed at 6pm. Any calls to the practice in this time were diverted to a mobile phone, manned by the practice manager or another member of reception staff.

When we checked this phone, we found three calls had been made to the phone but not answered. We were told that the staff member manning the phone would have access to an iPad. When we checked we saw that this had not been used to access the appointment system and offer an appointment to a patient. We asked how patients calling the practice between 6pm and 6.30pm would actually be handled. The practice manager told us they would be asked to ring the practice the next day to make an appointment. This effectively meant that the practice was not providing services between 6pm and 6.30pm.

We also noted there was evidence that calls were still being diverted to the mobile phone after 8am the following day, when the practice should be open.This could potentially mean that patients calling the practice in the out of hours period, from 6.30pm to 8am are not reaching the correct recorded message that diverts them to the NHS111 service.

Arrangements to deal with emergencies and major incidents

The practice arrangements to respond to emergencies and major incidents were insufficinet.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Three out of four of the practice staff and the ANP had received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises. There were emergency medicines available for use. All medicines were in date and suitable for use. However, the oxygen cylinder was empty. This was replaced by the locum GP before the end of the inspection day. There were adult and children's masks available for use with oxygen.
- A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew of their location.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with relevant evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The audit work we were shown by GPs was limited; there was no evidence of quality improvement activity. For example, we saw there was continuing work on a diabetes audit conducted by the Advanced Nurse Prescriber (ANP). This was aimed at driving up patients engagement for management of diabetes but there were no innovative steps in place to engage with patients who did not routinely attend diabetes management and care appointments.
- There was an audit on antibiotic prescribing. This was a two cycle audit of prescribinginitiated by medicines management and run for a second time by the practice manager. This lacked investigation as to why instances of prescribing had dropped slightly from 30 cases to 27 cases and whether NICE guidance had been adhered to in each case.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recently published results for 2015-16 showed the practice achieved 81% of points available (451.67 out of 559 points) with an overall exception reporting of 12%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This achievement was 13% lower than the CCG average and 12.5% lower than the national average achievement of practices in terms of overall QOF scores. This was also slightly lower than the previous years achievement for the practice, which for 2014-15 was 85% of available QOF points. There were no innovative methods or steps in place to address this.

Data from 2015-16 showed:

- Performance for diabetes related indicators was similar to CCG and national averages in six of the eleven care indicators. Other indicators were either in line with or below CCG and national averages and some of these had higher levels of exception reporting.
- For example, the percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90, was 92%. CCG average 91%, national average 91%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 81%. CCG average 78%, national average 80%.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 59 mmol/mol or less in the preceding 12 months was 57%. CCG average 71%, national average 70%.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months was 68%. CCG average 78%, national average 78%.
- The percentage of patients with diabetes, on the register, with a record of foot examination and risk classification was 91.5%. CCG average 84%, national average 88.5%.

  The practice had an on-going diabetes audit, to check on completed care interventions with diabetes patients. When we reviewed this we saw no change in how the practice tried to engage with patients to increase the number of successful interventions with diabetes patients.

  Performance for mental health related indicators was significantly worse than the national average. For example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had an

agreed comprehensive care plan documented in their record within the preceding 12 months was 46%, compared to the CCG average of 89% and national average of 89%.

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of alcohol consumption in the preceding 12 months was 66%, compared to the CCG average of 89% and national average of 89%.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face to face meeting in the previous 12 months was 67%, compared to the CCG average of 86% and national average of 84%. We noted that the practice exception reporting rate for this intervention was 25%, which is 20% higher than the CCG average and 18% above the national average. There were no plans or innovative steps to address this.

We noted that performance for care indicators for people with respiratory illnesses (COPD) was lower than local and national averages, with higher rates of exception reporting. For example:

- The percentage of patients with COPD in whom the diangsoses had been confirmed by spirometry between three months and 12 months of entering onto the disease register, was 92%, compared to the CCG average of 86% and national average of 89%. However, the rate of exception reporting for this care indicator was 37%, which was 24.5% higher than the CCG average and 28% above the national average.
- The percentage of patients with COPD who had undergone a review with a healthcare professional including an assessment of breathlessness in the preceding 12 months was 100%, compared to the CCG average of 87% and national average of 90%. However, the rate of exception reporting for this care indicator was 29%, compared to the CCG average of 14.5% and national average of 11.5%.
- The percentage of patients with COPD who received an influenza immunisation in the preceding 1 August to 31 March was 100%, compared to the CCG average of 97% and national average of 97%. The rate of exception reporting for this care intervention was 37%, compared to the CCG average of 21% and national average of 18%.

The practice had not implemented any plan to improve QOF interventions, to increase engagement with these patient groups or to reduce the higher rates of exception reporting.

We did review an audit on exacerbation of COPD had been conducted. This was a two cycle audit which brought to light those patients who required a review of their care and treatment. These patients were correctly coded on the clinical system and were subject to further call and recall for regular appointments with the Advanced Nurse Prescriber. However there was no available evidence of quality improvement.

The practice participated in local audits with the medicines management team, for example, on antibiotic prescribing to check that prescribing followed national and local guidance. The practice also took part in an audit on the numbers of women from ethnic minority backgrounds attending cervical screening, and on patients from ethnic minority backgrounds attending bowel screening appointments. This audit was run by the Lancashire Black Minority Ethnic Network. The result of the audit was given as the numbers of people attending screening, but there was no clear plan as to how the practice would continue to engage with these harder to reach patients, after the screening programmes.

Effective staffing

We did not see that all staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, fire safety, health and safety and confidentiality. However, there was no infection control training included in the induction and there was no infection control training in place for staff at the practice.
- The practice demonstrated they ensured role-specific training and updating for relevant staff. For example, for the ANP who was reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were not assessed or identified through a system of appraisals, meetings and reviews of practice development needs. The last appraisal of the ANP was March 2011. We saw evidence that the ANP had managed their own training and development through CCG led courses and nurse leads in the locality, as well as attendance at protected learning time events. We were able to see an appraisal of the practice manager from December 2016 and two other members of administrative staff, but for one staff member there was no evidence of appraisal. There had been no internal review of the work of the locum GP by the principal GP.
- Staff did have access to appropriate training to meet their learning needs and to cover the scope of their work but there were gaps in this training, for example, in infection control. There was also no whistleblowing policy in place and staff had not received any training on this.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. However, there were gaps between what had been agreed at multi-disciplinary meetings and patients being referred to community health services as required.

- We saw evidence of care plans, medical records and investigation and test results shared with the multi-disciplinary team.
- The practice shared relevant information with other services. However, referrals to other services were not always followed up and checked.For example, we saw two sets of minutes from multi-disciplinary team meetings. These showed that a patient needed a referral to the district nursing team for care and treatment of pressure sores. When we reviewed practice records, there had been no referral to the district nursing team for treatment of pressure sores. When we asked the practice manager about this, they agreed they could not find the referral. We also highlighted that there was no system in place to follow up these referrals to check that the required care was being delivered.

Staff worked with other health and social care professionals to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Some clinicians understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However, we found one of the clinicians was not clear on the requirement to report deaths to the coroner, of any person subject to a Deprivation of Liberty Order (DoLS). We were told that training on the Mental Capacity Act was due to be delivered to all clinicians, by the CCG.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example patients receiving end of life care, carers and mental health patients. Patients were signposted to relevant services for further support and advice.

The practice's uptake for the cervical screening programme was 78%, which was comparable to the CCG average of 80%% and the national average of 81%. There was a policy to offer a telephone and a postal reminder for patients

Inadequate

Are services effective?

(for example, treatment is effective)

who did not attend for their cervical screening test. From figures provided after the inspection, we saw that this initiative had achieved a small increase in attendance. For example, from 125 reminder letters sent, thirteen people had responded. The practice were not able to demonstrate how they encouraged uptake of the screening programme, for example, by using information in different languages and for those with a learning disability. The ANP delivered cervical screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening and the practice showed us an audit that they had been involved in which aimed to increase the numbers of patients from black and ethnic minority backgrounds to attend cervical screening and bowel screening programmes.

Childhood immunisation rates for the vaccinations given to 12 and 24 month old children were comparable to CCG/ national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 97%. Immunisation results were comparable to CCG and national averages for five year olds in six out of the ten vaccinations given. The other four immunisation rates were lower by approximately 20 – 30%.

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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. However we were told that a lot of the practice patient population did not attend for follow-up appointments. We did not see any action plans in place to address this.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- However, it was noted that some staff spoke about patients in derogatory terms and lacked empathy when relating to patients needs.

Care Quality Commission cards were made available two weeks before our inspection, for patients to record their views on the service provided by the practice. We received two completed comment cards, one from a staff member and another from a patient. Both recorded positive comments. The patient completed card recorded that they found services to be good.

The practice had not been able to form a patient participation group (PPG). We were told that this was because patients did not want to commit to meetings, whether they were formally held meetings at the practice or virtual meetings.

We observed how staff interacted with patients when arriving for appointments. There were no posters displayed in alternative languages, for example, in Polish or other Eastern European languages, where a number of patients using the practice are from.

Results from the national GP patient survey showed patients responses to questions around compassion, dignity and respect, were less favourable than CCG and national averages. Results from the survey were published in July 2016; 359 survey forms were distributed and 76 were returned. This gives a response rate of 38%. The views expressed represent 2% of the practice population.

- 69% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 72% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 64% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 74% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 91%.
- 81% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

When we asked, the practice told us there was no plan in place to address these scores. We were shown two surveys that the practice had conducted in May and October 2016. The response rate to the surveys was low, with 17 responses received in May and 24 responses received in October. The analysis of the sample of questionnaires received represented 0.5% of the practice population.

Results from the survey showed satisfaction rates with reception staff had dropped. The summary of findings said an action plan would be devised with the main aim being "to get the whole practice team behind the questionnaire." However, the action plan discussions would start in the New Year (2017). There was no focus on the results of the NHS GP Patients Survey, which did have a higher response rate and was independently conducted.

Care planning and involvement in decisions about care and treatment

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

- 67% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 64% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 82%.

Inadequate

Are services caring?

- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

Throughout the day when we spoke with staff at the practice, they often referred to patients as failing to engage. There were no plans in place to increase patient engagement. When asked, staff were not immediately aware of what percentage of the practice population did not have English as a first language, and whether rates of adult literacy rates were lower in the area than those nationally. We asked the practice to check the practice register to establish the number of patients who did not have English as a first language. We were told the figure was 1,970 patients who had declared that English was not their first language. This was not reflected in poster displayed in the waiting and reception area, or in literature available for patients to take away with them.

- Staff told us that translation services were available for patients who did not have English as a first language.
- There were no information leaflets available in reception and waiting areas in easy read format or in alternative languages. Any patients who required information in another language could request this.
- A hearing loop was available for patients with impaired hearing.

Patient and carer support to cope emotionally with care and treatment

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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 14 patients as carers. (Less than 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Other than the offer of an annual flu vaccination, GPs could not say how they supported carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them and offered a consultation at a flexible time to meet the family's needs or by giving them advice on how to find a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed 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. For example, the practice had a shared care agreement with a local drug addiction service, and provided help and support to patients wishing to reduce their of non-prescribed drugs.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients. We were told patients who had clinical needs which resulted in difficulty attending the practice, could also book home visits. However we saw some instances were this was not applied to some vulnerable patients.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS.
- There were disabled facilities, a hearing loop and translation services available for those that required these.
- There was no practice website available.
- there were no trained chaperones in the practice, other than the ANP and the female, principal GP who worked two and a half days each week. This impacted on access to some services, for example, women attending for cervical screening. Any patient who asked for a chaperone would have to book an appointment when both the nurse and the female GP were both available, which may not always have been convenient.

On the day of inspection, we were unable to speak with patients due to the limited time we had available, and the lack of patients available at that time in the day.

Access to the service

The practice is advertised as being open between 8am to 6.30pm Monday to Friday. However, the practice is closed from 6pm. The practice does not offer any extended hours surgeries. When we asked why this was we were told that because the building closed at 6pm, there was no facility to offer extended hours. No work had been undertaken to find out how the practice could make arrangements to open earlier or later, in response to patient demand, or share an extended hours surgery of a neighbouring GP practice.

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

- 65% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 78%.
- 63% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% national average of 73%.
- 80% of patients said the last time they needed to see or speak to a GP or nurse, they were able to get an appointment.
- 89% of patients said last time they got an appointment it was convenient compared to the CCG average of 93% and national average of 92%.
- 62% of patients described their experience of making an appointment as good, compared to the CCG average of 74% and national average of 73%.
- 59% of patients said they would recommend their surgery to someone who had just moved to the local area, compared to the CCG average of 81% and national average of 79.5%.

The practice had a system in place to assess:

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

All requests for home visits were reviewed by GPs who decided whether a home visit was necessary. 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.

Accident and emergency attendances for patients from the practice were relatively high; for the period November 2015 to October 2016, data from NHS Business Intelligence systems showed 1,193 patients visited accident and emergency units which represents over 30% of the practice population. Work in place to reduce this figure consisted of discussion of these patients at multi-disciplinary team

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

meetings. There was no work to investigate what circumstances caused patients to present at urgent care units, or plans to introduce measures aimed at reducing this.

From review of significant events, we found that the practice were not responsive when dealing with patients with long term conditions who were not always compliant with their care regime. In one example, we saw a patient who missed health checks critical for managing and monitoring their condition, did not have their care delivery reviewed to establish whether there was more the practice could do to improve the care outcomes for this patient. As a result of missing these appointments, the patient's condition deteriorated. In the review of the incident, the GP did not consider the use of community based nurses to help the patient manage their condition. A second example we reviewed showed that the GP had not considered the impact home visits or community nurses could have had on the care of the patient, and in helping with other issues around pain relief.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. However we found this to be ineffective. The practice said it had not received any complaints from patients for "four or five years". When we asked about verbal complaints, we were told these were not recorded. For a patient to raise a complaint, they would have to ask reception staff for a complaints form and a copy of the practice complaints policy. We pointed out that this may deter patients from raising concerns or complaints. There was a designated responsible person for handling all complaints in the practice, which was the practice manager.

Although the practice invited patient feedback, we saw no evidence that it acted on this.

The practice had conducted a patient survey/satisfaction audit, which was carried out in May and October of 2016. Response rate to this was low. The practice planned to meet after Christmas 2016 to discuss the results, but at the time of our inspection there was no action plan in place to focus on improvements. We also noted that the practice did not advertise the monthly results of the NHS Friends and Family test in the practice.

As part of the information return submitted before our inspection, a separate analysis of a different practice survey conducted in March 2016 was submitted. The practice issued 150 questionnaires and 54 were returned. Results showed:

- satisfaction with contact with the receptionist - 89% of respondents said they had a positive experience;
- 11% said they had a poor or very poor experience.
- Eight comments were submitted by patients; seven were positive.
- In relation to contact with the GP, 84% of 48 respondents said their contact was positive.
- 16% of patients said their experience was poor or very poor.
- Of three comments made against this question, two were positive, one was negative.
- When patients were asked about their overall experience, 82% of patients said it was positive, 18% said it was either poor or very poor.
- Three comments by patients next to this question were negative.

From analysis of 11 comments and suggestions made by patients overall, seven were negative, three were positive and one was neutral. The conclusion of the survey was that patients are overall satisfied with the practice. There was no reflection by GPs on the negative comments made about their interaction with patients; there was no link to the two cycle audit of patients feedback conducted in May and October to look for themes or trends or comparison with results from the NHS England GP Patient Survey.

There were no documents for us to review to check how any complaints or concerns were handled, as no complaints had been received.

We were told that staff safety was a concern however there were no recorded significant events in relation to patients displaying unacceptable behaviours. There were no figures available from the practice on how many times the police had been called to deal with they types of incidents referred to by the practice. There was insufficient evidence that the hardline attitude of the practice towards some patients was justified.

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

There was no clear vision to deliver high quality care and promote good outcomes for patients.

- There was no practice mission statement, or values and behaviours encouraged by the practice leaders, to motivate all involved to deliver high quality services.
- The practice did not have a formal strategy and supporting business plans and there was no formal succession planning in place for when the principal GP retired.

Governance arrangements

The practice had a governance framework but this was not routinely followed and monitored. There were elements of governance missing, for example, a whistleblowing policy and whistleblowing training for staff. Other training required by staff had not been delivered such as infection control and the person appointed as deputy lead for infection control did not understand the levels of cleaning required in a primary care setting and how to monitor these.

- There was a clear staffing structure in place
- Evidence on the day showed that not all staff were aware of the extent of their own roles and responsibilities.
- Some generic policies had been adopted as practice specific policies. However some of these had not been reviewed fully, for example, there were names missing in the safeguarding policy indicating who was the safeguarding lead and who the deputy was.
- An understanding of the performance of the practice was not in place for all staff.
- There was no continuous programme of clinical audit to monitor quality and to make improvements.
- Arrangements for identifying, recording and managing risks and issues were insufficient. When factors that impacted on significant events were reviewed, learning points were not applied. This meant that some aspects of patient care did not improve.

Leadership and culture

On the day of inspection the principal GP and practice manager failed to demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. Although they told us they prioritised safe, high quality and compassionate care, evidence gathered through inspection did not support this. The principal GP did not consider the derogatory terms that some staff referred to patients in as being unacceptable.

The provider was aware of and had systems in place 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 practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support and information and a verbal apology when required
- The practice kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and staff said they felt supported by management.

- Staff told us the practice held regular meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at meetings and felt confident to do so. The practice also had protected learning time meetings with their buddy practice as short distance away.
- Staff said they felt valued and supported.

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

There was no practice website and when we reviewed all information on the practice notice boards and in the area around reception, there were no posters advertising how any patients suggestions had been implemented.

Continuous improvement

There was a lack of focus on continuous learning and improvement at all levels within the practice. There appeared to be a lack of openness to change following review of significant events. From those we were able to review, there was no improvement in patient care.

The principal GP did not periodically review the work of the practice manager. For example, in checking how diverted

Are services well-led?

Inadequate

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

phone calls received between 6pm and 6.30pm had been managed and addressed, how infection control training was planned and implemented for staff, or how cleaning checks and infection control audits were managed. The practice manager was not sure about whether they were the deputy lead for safeguarding and the extent of this role.

There was a lack of knowledge about patients level of literacy and the impact of this; nobody had queried why no complaints had been received by the practice for four years or more. This and the general lack of leadership of staff at the practice, impacted on patients in a negative way.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. Steps to manage risks to patients who were not compliant with their treatment regime were not in place. Learning from incidents involving patients care was not evident. The oxygen cylinder for use in emergencies was empty. There was no recent audit on infection control. There was no effective management of the cleaning of the practice. Staff had not received training in infection control. This was in breach of regulation 12 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 Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

This section is primarily information for the provider

Enforcement actions

The provider could not show sufficient evidence of effective clinical audit, learning from audit and results of audit driving improvement.

The safeguarding policy within the practice was ineffective. Staff did not know who the deputy safeguarding lead was, including the practice manager who thought it was their responsibility.

Where risks were identified the provider failed to introduce measures to reduce or remove risks. There was no action plan in place to address the high numbers of patients attending local accident and emergency units. GPs had not conducted any follow-up work to understand why patients were using these acute care units. No changes were made to services at the practice to reduce these numbers.

One member of staff had not received safeguarding training.

The practice nurse had not been appraised since 2011.

The practice did not hold records of checks required to be carried out on staff. Evidence of DBS checks for clinicians and evidence of their medical indemnity were brought to the practice on the day of inspection at the request of the inspection team.

The practice had failed to respond effectively to negative feedback from patients from several sources. Complaints made verbally were not recorded and there was evidence that the complaints system for the practice was not easily accessible to patients.

There was no action plan in place to address poor QOF performance.

There was no formal business review or succession planning in place.

Access arrangements for patients between 6pm and 6.30pm had not been reviewed. We found evidence that access arrangements for patients in this time period were ineffective.

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