Failsworth Group Practice

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
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 Failsworth Group Practice on 8 December 2015. Overall the practice is rated as inadequate.

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 checks on staff had not been undertaken prior to their employment.
- Staff were not clear about reporting incidents, near misses and concerns and there was no guidance available for them to follow.
- Clinically, patient outcomes were identified and there was reference made in audits to quality.
- Patients were unclear how to complain and information was not easily available. The complaints' policy did not contain all the required information.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Appointment systems were not working well so patients did not receive timely care when they needed it.
- There was insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Ensure the safeguarding policy contains up to date information to guide staff. Ensure all staff are aware of who the practice leads are for safeguarding. Ensure all staff have received appropriate safeguarding training.
- Ensure the complaints' policy includes the required information and patients are able to easily find out how to make a complaint. To also ensure complaints' responses are in line with current legislation.

Summary of findings

- Ensure there are policies and procedures in place to guide staff and ensure effective governance systems. To use the views of patients to improve aspects of the service. To put systems in place so when quality and safety is compromised this is recognised. To ensure appointment availability is monitored appropriately so access issues are identified.
- Ensure all staff receive appropriate training on induction, and effective training at the required intervals. To ensure the practice manager is supervised.
- Ensure recruitment arrangements include all necessary employment checks for all staff.

The areas where the provider should make improvement are:

- Give guidance to staff so they understand what a significant event is so all appropriate events are correctly recorded and actioned.
- Improve the infection control policy so more guidance is available.
- Bring the mission statement to the attention of all staff.
- Put in place a remit for the patient participation group and liaise with them in order for them to feel the practice is receptive to their ideas.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff were not always clear about reporting significant events. Not all non-clinical staff were sure what a significant event was and a definition and process for reporting a significant event was not documented.
- Patients were at risk of harm because systems and processes were not in place or not being followed. For example, staff performed chaperone duties without a Disclosure and Barring Service (DBS) check being in place and adequate recruitment procedures were not in place. We found blank prescriptions stamped with the practice stamp in an unlocked room and there was no record kept of prescription serial numbers. Some needles and syringes were beyond their expiry date.
- There was insufficient attention to safeguarding. There was a policy but some of the guidance in it was out of date. Leads for safeguarding children and vulnerable adults had volunteered in the month prior to our inspection but this information was not in the policy. The majority of staff were unaware of who the leads were. Not all staff had received training and some clinicians' training was not at the required level.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data showed patient outcomes were usually in line with or above the local average.
- GPs had knowledge of national guidelines and could demonstrate they referred to them appropriately.
- Clinical audits were carried out as a way to drive improvement in performance and improve patient outcomes.
- Multidisciplinary working was taking place with appropriate records kept.
- The majority of training records available were for e-learning carried out during the three weeks prior to our inspection.
- It was usual for several training courses to be completed on the same day in a very short period of time, for example 10 courses being completed in a day, with the period between ending the first course and ending the 10th course being 37 minutes.

Summary of findings

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. This is due to concerns within the practice that have an impact on all patients across the domains. However, we saw some examples of positive practice.

- Data showed that patients rated the practice in line with others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice had some information available for patients about the services.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Extended hours opening was available daily, with appointments from 7am Monday to Friday.
- Feedback from patients reported that access to a GP was not always available quickly. There was no protocol for staff to assess the urgency of an appointment and no consistency in the allocation of appointments.
- Apart from not having a hearing loop the practice was equipped to treat patients and meet their needs.
- Although patients could get information about how to complain in a format they could understand this was not readily available. The complaints' policy, and information available for patients, did not contain all the relevant information. The Registered Manager told us patients received responses to their complaints but a record was not always kept of this.

Are services well-led?

Inadequate

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

- The practice had a mission statement but not all staff were aware of this. There were no governance structures in place to reflect the vision and values.
- Staff told us they were clear about their responsibilities but protocols were not in place to guide them.
- The practice had some policies and procedures, but these were usually brief and did not contain the level of details required to guide staff. Some were not practice specific.

Summary of findings

- The practice had a patient participation group (PPG) but they were unclear of their remit. Some of the group we spoke with told us the practice was not receptive to their ideas.
- There was no evidence of the national GP patient survey being reviewed to see if patient satisfaction had improved. There was an access action plan but no evidence that changes made had increased satisfaction with access to appointments.
- Staff told us they received regular appraisals, but there was no management of the practice manager who was also the Registered Manager. There were no formal inductions for new staff.
- The partners at the practice had changed approximately 18 months prior to the inspection. Two weeks prior to the inspection the CQC was notified that two partners had left. No application had been received to register the two new partners so the registration was incorrect.

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 practice was rated as inadequate for safe, responsive and well-led care, and as requires improvement for the effective and caring domains. The concerns which led to these ratings apply to everyone using this practice, including this population group. There were however some examples of good practice.

- Care and treatment of older people reflected current advice.
- Older people had care plans where necessary.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were positive.
- The percentage of people aged 65 or over who received a seasonal flu vaccination was lower than the CCG and national averages.
- Longer appointments and home visits were available for older people when needed.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care people with long term conditions. The practice was rated as inadequate for safe, responsive and well-led care, and as requires improvement for the effective and caring domains. The concerns which led to these ratings apply to everyone using this practice, including this population group. There were however some examples of good practice.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The practice was rated as inadequate for safe, responsive and well-led care, and as requires improvement for the effective and caring domains. The concerns which led to these ratings apply to everyone using this practice, including this population group. There were however some examples of good practice.

Summary of findings

- Although all GPs had received safeguarding training to the appropriate level not all staff had received training.
- Immunisation rates for the standard childhood immunisations were comparable to or above average.
- Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this.
- Appointments were available outside school hours.

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 practice was rated as inadequate for safe, responsive and well-led care, and as requires improvement for the effective and caring domains. The concerns which led to these ratings apply to everyone using this practice, including this population group. There were however some examples of good practice.

- Early morning appointments were available so patients who worked could be seen outside normal working hours.
- There were several ways of booking appointments but the patients we spoke with were not aware of all these ways.
- NHS health checks were available for patients over the age of 40.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice was rated as inadequate for safe, responsive and well-led care, and as requires improvement for the effective and caring domains. The concerns which led to these ratings apply to everyone using this practice, including this population group. There were however some examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- There were no policies or arrangements to allow people with no fixed address to register or be seen at the practice.
- The practice worked with multi-disciplinary teams in the case management of vulnerable people.
- Not all staff had been trained in safeguarding vulnerable adults and children.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care people experiencing poor mental health (including people with dementia). The practice was rated as inadequate for safe, responsive and well-led care, and as requires improvement for the effective and caring domains. The concerns which led to these ratings apply to everyone using this practice, including this population group. There were however some examples of good practice.

- The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health.
- It carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including Tameside, Oldham and Glossop MIND. MIND attended the practice twice a week.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in July 2015. The results showed the practice was usually performing below local and national averages. 340 survey forms were distributed and 112 were returned. This was a 33% completion rate, representing less than 1% of registered patients.

- 34% found it easy to get through to this surgery by phone compared to a clinical commissioning group (CCG) average of 70% and a national average of 73%.
- 82% found the receptionists at this surgery helpful (CCG average 87%, national average 87 %%).
- 77% were able to get an appointment to see or speak to someone the last time they tried (CCG average 80%, national average 85%).
- 85% said the last appointment they got was convenient (CCG average 91%, national average 92%).
- 48% described their experience of making an appointment as good (CCG average 70%, national average 73%).
- 82% usually waited 15 minutes or less after their appointment time to be seen (CCG average 71%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 10 comment cards, which all contained some positive comments. Four of these had been completed by staff.

We spoke with 21 patients during the inspection. All 21 patients made positive comments about staff, including reception staff and clinicians. The majority of the patients we spoke with told us they had difficulty booking appointments.

Areas for improvement

Action the service MUST take to improve

- Ensure the safeguarding policy contains up to date information to guide staff. Ensure all staff are aware of who the practice leads are for safeguarding. Ensure all staff have received appropriate training.
- Ensure the complaints' policy includes the required information and patients are able to easily find out how to make a complaint. To also ensure complaints' responses are in line with current legislation.
- Ensure there are policies and procedures in place to guide staff and ensure effective governance systems. To use the views of patients to improve aspects of the service. To put systems in place so when quality and safety is compromised this is recognised. To ensure appointment availability is monitored appropriately so access issues are identified.
- Ensure all staff receive appropriate training on induction, and effective training at the required intervals. To ensure the practice manager is supervised.
- Ensure recruitment arrangements include all necessary employment checks for all staff.

Action the service SHOULD take to improve

- Give guidance to staff so they understand what a significant event is so all appropriate events are correctly recorded and actioned.
- Improve the infection control policy so more guidance is available.
- Bring the mission statement to the attention of all staff.
- Put in place a remit for the patient participation group and liaise with them in order for them to feel the practice is receptive to their ideas.

Failsworth Group 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 practice manager specialist advisor and an Expert by Experience.

Background to Failsworth Group Practice

Failsworth Group Practice is located on the first floor of a modern building on a retail park in Failsworth. There are two other GP practices located in the same building. The practice is fully accessible to those with mobility difficulties. There is a car park next to the building entrance

There are four female GPs and three male GPs working at the practice. There are two nurse practitioners, five practice nurses and two healthcare assistants. There is also a practice manager, who is the CQC Registered Manager and referred to as the Registered Manager throughout this report, and reception and administrative staff.

The practice is open from 8am until 6.30pm Monday to Friday. Appointments are from 7am until 6pm Monday to Friday.

The practice has a Personal Medical Service (PMS) contract with NHS England. At the time of our inspection approximately 13,000 patients were registered.

The practice is a training practice for medical students, foundation doctors and specialty trainee GPs.

The practice has opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider, Go to Doc.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 December 2015. During our visit we:

- Spoke with a range of staff including three GPs, the practice manager, a practice nurse, a nurse practitioner and administration and reception staff.
- We spoke with 21 patients, including five members of the patient participation group (PPG).
- Observed how people were being responded to at the reception desk.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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. 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

Clinical staff knew what constituted a significant event and knew the reporting process. Not all non-clinical staff were aware of what a significant event was and said they would tell the Registered Manager of anything they thought relevant. The Registered Manager told us the reporting process for significant events was not documented and they had not defined what a significant event was to staff.

We reviewed the four significant events that had been recorded in the previous 12 months. These documented who the Registered Manager thought was at fault and we saw no evidence that processes were in place to ensure significant events did not reoccur.

We saw evidence that significant events were discussed in practice meetings.

Overview of safety systems and processes

The practice did not have defined and embedded systems, processes and practices in place to keep people safe and safeguard them from abuse. For example:

- The practice had a safeguarding children and vulnerable adults policy. Some of the information in the policy referred to out of date guidance and the Registered Manager removed these references during the inspection. The policy stated that all clinical staff would have a Criminal Records Bureau (CRB) Check. The CRB ceased to exist on 1 December 2012 when the Disclosure and Barring Service (DBS) was formed. (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). We found that some clinical staff did not have a DBS check. We saw evidence in the practice meeting minutes from 12 November 2015 that a GP had volunteered to be the lead for safeguarding children. It was recorded that a lead for safeguarding adults was still required, but the Registered Manager told us another GP had now volunteered. This information was not included in the safeguarding policy. We spoke with several staff members; the practice manager, the lead and one other staff member knew who the safeguarding lead for adults was but no staff member (including the GP lead for adults) except the lead and the practice manager knew who the children's lead was.
- The safeguarding policy stated that non-clinical staff would receive level 1 training, clinical staff including GPs would have level 2 and GPs would work towards level 3. The Registered Manager stated this was out of date and GPs had level 3 training. We looked at the training records for all staff. These showed that not all staff had received training in safeguarding adults or children, and records showed not all nurses had training to the required level. The Registered Manager told us they had made safeguarding referrals during the previous 12 months but they were unable to give specific information.
- The practice had a chaperone policy but this did not give information about the procedure a chaperone should follow. The policy stated that chaperones should be trained and should not be left alone with a patient unless they had a DBS check. Although most staff had completed on-line chaperone training there was no DBS check in place for the majority of them. There was no risk assessment in place to determine if a DBS check for chaperones was necessary. The staff we spoke with were aware of their role and where to stand when chaperoning and GPs told us they preferred to have clinical staff to chaperone.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The Registered Manager was the infection control lead; they had completed on-line non-clinical infection control training. There was an infection control policy that stated "This policy gives information on the related policies, protocols and procedures which together meet the requirements placed up on us". It did not contain that information. It stated that all staff would be trained on induction and at regular intervals. We saw evidence that the majority of staff had been trained. This was via e-learning. An infection control audit had been carried out by the Registered Manager accompanied by two healthcare assistants in August 2015. Actions required following the audit were being taken.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice

carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. However, during the inspection we found three individual blank prescriptions, stamped with the practice stamp, in an unlocked room off a corridor where patients had access. The Registered Manager told us there was no monitoring of prescription pads and their serial numbers were not recorded when they were removed from storage.

- The Registered Manager told us that they held no hard copies of recruitment information. They said all information was scanned onto their computer and the hard copy destroyed. We reviewed the electronic records of 11 staff, including five who had been recruited within the previous six months. Very little information was held. We asked the Registered Manager what information they requested prior to employing a new staff member. They told us they did not seek references and did not ask for or keep information about the previous experience or qualifications of staff as they always recruited people they personally knew. They added that the assistant practice manager who started work in February 2015 had said they should start to request references. We looked at the records kept for a staff member who started in the two months prior to our inspection. They also had no application form or work history. Two references were held, but one was dated 2007 and another was undated. Identification for staff was not usually held although the Registered Manager told us all staff had an NHS Smartcard and identification would have been provided when this was issued.
- The Registered Manager told us they did not have a recruitment policy but used the 'NHS England Lancashire and Greater Manchester ID and DBS Checks for New Staff at GP Practices' document as a guide. This document stated that a copy of identification for staff should be taken to hold in personnel records, but this guidance had not been followed at the practice. The document also stated that the employer must check an individual's registration with their relevant regulatory body. Checks with the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) had not been carried out. The document further provided information about when a DBS check should be carried out. This guidance had not been followed. We saw that a DBS check had been carried out for two existing clinicians in the two weeks prior to our inspection. A nurse who had been employed in the six months prior to our inspection had provided a CRB check from 2009 when they worked in a different role for another organisation. This had been accepted contrary to the guidance the Registered Manager stated they followed.
- The Registered Manager told us they were unaware of the requirements of the Health and Social Care Act 2008 in relation to the recruitment of staff and they felt they were fulfilling their responsibilities by following the NHS guidance. However, we saw that the guidance had not been followed.

Monitoring risks to patients

Some risks to patients were assessed and managed.

- 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. The practice had up to date fire risk assessments and carried out regular fire drills. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The Registered Manager told us all staff received training in Basic Life Support. We saw that most staff had completed on-line training in Basic Life Support. Although we were told practical training had taken for GPs every year and for other staff every two years evidence for this was not available. The Registered Manager did find a training certificate from 2012 but said there had been training since then.

Inadequate

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. However, in an unlocked room that patients could access we found a supply of needles and syringes that were past their expiry date. These were removed from the room during our inspection.

The practice had a disaster recovery plan in place. This included telephone numbers to contact in certain situations such as a power failure. It also had telephone numbers for if a locksmith was required or if there were issues with the intruder alarm or telephones. It did not contain guidance for if key staff were absent or if the building could not be accessed. The contact numbers of staff were not included in the plan.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. GPs had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.
- The GPs informally monitored that these guidelines were followed.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results, for 2014-15, were 98.9% of the total number of points available. This was above the clinical commissioning group (CCG) average of 92.6% and the national average of 93.5%. There was 9.7% exception reporting, which was above the CCG and national average. Exception reporting ensures that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. Data from 2014-15 showed:

- Performance for diabetes related indicators was 96.5%. This was better than the CCG average of 81.8% and the national average of 89.2%. Some diabetes related indicators had high exception ratings. This included an exception rating of 39.5% for the percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who had a record of being referred to a structured education programme within nine months after entry on to the diabetes register.
- Performance for hypertension related indicators was 100%. This was better than the CCG average of 96.7% and the national average of 97.8%.
- Performance for mental health related indicators was 100%. This was better than the CCG average of 91.7% and the national average of 92.8%. Some mental health related indicators had high exception ratings. This included an exception rating of 39.7% for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate.
- Performance for dementia related indicators was 100%. This was better than the CCG average of 90.4% and the national average of 94.5%.

Clinical audits demonstrated quality improvement.

- We saw a selection of clinical audits that had been completed. These included audit cycles where the improvements made were implemented and monitored.
- The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services.

Effective staffing

There was little information available about the skills, knowledge and experience staff had to deliver effective care and treatment. The Registered Manager told us they held all documents electronically as they had a paperless practice. We saw a small number of historical documents were still available but these were being destroyed as they were scanned onto the computer.

- The practice did not have a formal induction programme. The Registered Manager told us all staff, including new staff, had access to on-line training and they could complete relevant courses. We saw no evidence that staff received guidance on what training to complete and saw no evidence their training was monitored to ensure mandatory training was completed.
- The practice could not demonstrate how they ensured role-specific training for relevant staff, for example those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. The practice nurses and nurse practitioners worked closely as a team to monitor

their continuing professional development (CPD) and ensure it was up to date, but this was not co-ordinated by the practice. The nurses we spoke with told us they kept their own evidence of clinical training, which they arranged as a team. The Registeterd Manager arranged their mandatory training.

- We saw no evidence of the learning needs of staff being identified. Brief appraisals had been carried out and we saw some evidence of appraisal documents. The Registered Manager told us that from 2015 all appraisal documents were held electronically and we saw some evidence of this. The Registered Manager told us all staff had had an appraisal within the past 12 months and we saw GP appraisals were up to date. The Registered Manager told us they usually had their appraisal with a GP, but they had requested this to be postponed this year so they could prepare for the CQC inspection.
- Over 75% of staff training evidence held was for e-learning carried out during the three weeks prior to our inspection. We saw many examples of several training courses being completed on the same day in a very short timeframe. For example, one clinician had completed 10 courses in one day. The period between ending the first course and ending the 10th course was 37 minutes. Another clinician had completed 12 courses in one day. The period between ending the first course and ending the 12th course was one hour five minutes. These courses included complex topics such as safeguarding adults and children, the Mental Capacity Act and infection control (clinical) where some courses had been completed in three minutes. This had not been recognised by the Registered Manager and the knowledge of staff had not been clarified. When we spoke with staff some told us they had not been trained in, for example, equality and diversity. Their training records showed they had been trained less than two weeks prior to our inspection. Staff told us they did receive on-going training but we saw no evidence of this. The Registered Manager told us that all training had been on-line and they did not keep any other training documentation.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. 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, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

Childhood immunisation rates for the vaccinations given were comparable to or above CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year were 73.5% (CCG uptake between 71.7% and 81.1%) and five year olds from 74.4% to 80.6% (CCG uptake between 68.8% and 72.3%). However flu vaccination rates were below average. The rate for over 65s was 66.24% (CCG average 73.24%) and the rate for at risk groups was 37% (CCG average 52.29%).

Requires improvement

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people 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 and that conversations taking place in these rooms could not be overheard.
- Reception staff said they knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Some aspects of the practice did not promote patients' dignity. For example a sign on the door of the patients' toilet informed patients they should ask at reception if they needed toilet roll. A similar notice advised that anyone caught stealing toilet rolls or soap would be struck off the practice list.

Three of the 10 CQC comment cards we received mentioned that staff were helpful, and staff were friendly and caring. The patients we spoke with told us they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with five members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the most recent national GP patient survey, published in July 2015, showed patients felt they were treated with compassion, dignity and respect. The practice was in line with the average for its satisfaction scores on consultations with doctors and nurses. For example:

- 83% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 82% said the GP gave them enough time (CCG average 86%, national average 87%).
- 93% said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%)
- 82% said the last GP they spoke to was good at treating them with care and concern (CCG average 83%, national average 85%).
- 94% said the last nurse they spoke to was good at treating them with care and concern (CCG average 90%, national average 90%).
- 82% said they found the receptionists at the practice helpful (CCG average 87%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us that 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 available to them.

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

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 84% said the last GP they saw was good at involving them in decisions about their care (CCG average 81%, national average 81%)

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups including a group for carers.

The practice's computer system alerted GPs if a patient was also a carer. Information was available to direct carers to the various avenues of support available to them.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had reviewed the needs of its local population when planning the times they delivered services.

- The practice offered extended hours appointments in the mornings. Monday to Friday appointments were between 7am and 6pm.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or other patients who would benefit from these. The nurse practitioner also visited patients at home.
- The Registered Manager told us that same day appointments were available for children and those with serious medical conditions. However, there were no protocols in place to guide receptionists and staff told us they used a 'common sense' approach. We saw there were inconsistencies in the way appointments were given to patients, but we did witness a mother being given an immediate appointment when they said they were concerned about their young child.
- When the all the appointments for the day had been filled patients were asked to telephone the following day. One patient gave us an example of them telephoning or visiting on multiple consecutive days. They told us they would attend A&E or the walk in centre if they could not access an appointment in another couple of days. The Registered Manager told us complaints about access to appointments had stopped since additional staff had been introduced, but the comments we received from patients during the inspection did not provide evidence of improvements taking place.
- The practice was on the first floor of a building. There was a passenger lift available. There was no hearing loop but staff told us they had a staff member available who could use sign language if required. There were no facilities for people who were hard of hearing and could not sign.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available from 7am until 6pm Monday to Friday. Appointments could be booked on the day or up to three weeks in advance.

Of the 21 patients we spoke with three said they were happy with the appointments system. These three patients said they had used the automated telephone system at 7.30am and were given an appointment that day. The remaining 18 said they had difficulty with the system and also found it difficult to access appointments. Four patients reported having an engaged tone on the telephone for up to 30 minutes and most others reported that when they got through on the telephone it was not unusual to be 9th or 10th in the queueing system with a wait of up to 10 minutes. Two patients told us that although there were difficulties with the appointment system they had found ways of 'getting round' the system. The Registered Manager said that if patients had complaints about the system patients should email them, and they had not received emails regarding this. They told us they thought the appointments system was working better as less patients complained. None of the patients we spoke with (that included five members of the patient participation group (PPG)) were aware of all the different ways they could book an appointment.

We saw the practice's access action plan. This had been updated 18 November 2015. Several items were noted as having being completed, some as far back as May 2012. Others were ongoing. Although several ideas had been discussed we saw no evidence of improvements in access being made. One aim was to reduce the number of patients on their list, and the Registered Manager told us the list had reduced by 800 patients since the idea was included on the action plan in March 2013. A GP told us they had not actively reduced the list size but had not actively recruited new patients when patients left the practice, therefore increasing the ratio of GPs to patients.

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

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 34% patients said they could get through easily to the surgery by phone (CCG average 70%, national average 73%).
- 48% patients described their experience of making an appointment as good (CCG average 70%, national average 73%.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 82% patients said they usually waited 15 minutes or less after their appointment time (CCG average 71%, national average 65%).

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns. There was a complaints' policy but this did not give information about how patients should complain and who was responsible for dealing with complaints. It did not mention the Parliamentary and Health Service Ombudsman (PHSO). The practice complaints leaflet was not freely available; patients had to ask for this, and it did not contain all the relevant information. Also the website did not include the relevant information about the complaints' process. The Registered Manager amended some of this during the inspection.

We looked at the electronic records of the 16 complaints made since 1 April 2014. Very little information was kept. We looked at the two most recent complaints in more detail. We saw one had been responded to by email and information about the PHSO had not been included. The Registered Manager told us they resolved the other complaint by telephone but did not keep a record of the telephone call.

There was no information in the reception area about how to complain. Patients had to ask a receptionist for the complaints' leaflet or the relevant form. None of the 21 patients we spoke with (including five members of the PPG) were aware of how to raise a complaint with the practice.

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 Registered Manager told us the practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement, "Here to help you look after your health". Not all staff were aware of this.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However although certain staff groups, for example the GPs and the nursing team, worked well together, there was no adequate overall management of the practice.
- We saw examples of policies, but some of these were not specific to the practice and most did not contain the level of information required to guide staff.
- The Registered Manager told us they did not keep a record of previous versions of policies; they overwrote them when they were reviewed. They told us that they tried to keep a paperless office and therefore kept as little paperwork as possible.
- Although the GPs had a comprehensive understanding of the clinical performance of the practice the partners were unaware of issues relating to the management of the practice. The practice manager was the Registered Manager and they were unaware of the requirements of a CQC Registered Manager and also unaware of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The partners had not recognised this or taken action in line with their responsibilities.
- There was a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing clinical risks, issues and implementing mitigating actions. However, other risks within the practice had not been identified.
- Since the practice had registered with the CQC the partnership had changed. Two partners had left several months previously. The practice had applied to remove them from their registration two weeks prior to the inspection and this was being processed by the CQC. Two other partners had joined the practice. One of these started in September 2015. The personnel records for the other partner stated they started in September 2013. One of the GPs explained they were a locum GP at this time and became a partner approximately 18 months ago. No application had been received to register these partners so the current CQC registration was incorrect.

Leadership, openness and transparency

The partners in the practice had been involved in all clinical aspects of running the practice. However, they had not been involved in the management of the practice and not recognised the issues relating to improvements that need to be made. The partners 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.

The Registered Manager at the practice was the practice manager. They told us they did not have a line manager and if they had an issue at the practice they would raise it in a clinical meeting. They told us they had an appraisal by a GP and the GPs rotated this responsibility each year. The Registered Manager told us they had postponed their appraisal this year until after the CQC inspection.

When there were unexpected or unintended safety incidents:

- The practice did not have a protocol for reporting incidents and some staff were unsure of what should be reported. This meant the practice could not be sure safety incidents were correctly responded to.
- They did not keep written records of verbal interactions as well as written correspondence.

Although there was no clear leadership structure in place, staff told us they felt supported by management, including the Registered Manager and the GPs.

- Staff told us that the practice held regular team meetings.
- Staff told us that they felt the Registered Manager treated them in a fair way.

Are services well-led?

Inadequate

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

- Staff told us there was no whistleblowing policy and if they had any issues they would approach the Registered Manager.

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

The practice told us they encouraged and valued feedback from patients, the public and staff.

- There had been a patient participation group (PPG) for approximately five years. We met with five members who told us approximately 12 of them met four times a year. The group told us they were unsure of their remit but thought it was to feedback patient views to the practice about improvements that had been made. However, not all the members we spoke with told us the practice was receptive to any ideas they suggested.
- The PPG did not carry out any satisfaction surveys, and the practice had not carried out their own survey. Although the practice had an access action plan that had been in place for almost four years we saw no evidence that the plan was updated or patient satisfaction scores re-analysed each time the national GP satisfaction survey results were updated.
- During our inspection there was no NHS Friends and Family Survey box in the waiting area. When we mentioned this the box was found behind reception. Staff told us it was usually available but had been removed while the CQC comments cards box was on display.

Continuous improvement

There was a strong focus on clinical continuous learning and improvement within the clinicians at the practice. The practice was a training practice for medical students, foundation doctors and speciality trainee GPs. They told us they saw their trainees as future potential partners and therefore ensured their training met the needs of the practice population. Although there was a strong emphasis on this training, training for staff employed by the practice was not well managed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered person did not have a safeguarding policy that contained up to date guidance. Not all staff had been trained in safeguarding children or vulnerable adults. The majority of staff were unaware of who the practice lead was for safeguarding children or vulnerable adults as they had only been appointed during the month prior to the inspection. This was in breach of Regulation 13(2) of the Health and Social Care Act 2008 (RA) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints We found that the registered person did not include all the required information in their complaints policy. Information about how to complain was not easily available to patients. There was no information available about how a complainant could take further action if they were not satisfied with how the provider managed or responded to complaints. This was in breach of Regulation 16(1) (2) of the Health and Social Care Act 2008 (RA) Regulations 2014.

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 registered person did not have all the required practice specific policies and procedures in place. Systems and processes were not in place to

This section is primarily information for the provider

Requirement notices

identify when the quality or safety was compromised. This included monitoring the effectiveness of the appointments system. The feedback of patients, for example in the national GP patient survey, was not adequately acted on. Accurate safety checks were not carried out to ensure prescriptions were kept secure and equipment was within its expiry date. The registered person did not ensure their governance systems were effective. The practice had not kept the CQC up to date with changes in the partnership so the registration was incorrect.

This was in breach of Regulation 17(1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (RA) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person did not ensure staff received appropriate training on induction or effective on-going training. The practice manager was not supervised or managed. This was in breach of Regulation 18(2) (a) of the Health and Social Care Act (RA) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person did not operate a robust recruitment system. There was no recruitment policy. The information required in Schedule 3 was not held for staff and Disclosure and Barring Service (DBS) checks had not been carried out for all appropriate staff. The current registration status of GPs and nurses had not been checked. This was in breach of Regulation 19(1)(a)(b)(2)(3)(a) of the Health and Social Care Act 2008 (RA) Regulations 2014