Dr Ahmed Choudhury

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate. (Previous inspection March 2015 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires improvement

Are services responsive? – Requires improvement

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions - Inadequate

Families, children and young people - Inadequate

Working age people (including those retired and students) - Inadequate

People whose circumstances may make them vulnerable - Inadequate

People experiencing poor mental health (including people with dementia) - Inadequate

We carried out an announced comprehensive inspection at Dr Ahmed Choudhury (also known as Oldham Family Practice) 0n 6 December 2017. This inspection was part of our inspection programme.

At this inspection we found:

- The practice did not have clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice did not always record or investigate, so learning from them was not demonstrated.
- The practice did not routinely review the effectiveness and appropriateness of the care it provided. Care and treatment was not always delivered according to evidence- based guidelines.
- Patients commented that appontments were usually available and they could access care when they needed it.
- Staff treated patients with kindness, dignity and respect.
- There was little innovation or service development and improvement had not been a priority among staff and leaders.

Summary of findings

The areas where the provider **must** make improvements as they are in breach of regulations are:

- The provider must ensure safe care and treatment is provided.
- The provider must ensure patients are safeguarded from abuse and improper treatment.
- The provider must have a system in place to ensure all complaints are recorded, investigated and appropriately responded to.
- The provider must improve their governance arrangements.
- The provider must ensure all staff are suitably qualified, skilled, trained and supported.

The area where the provider should make improvements are:

- The provider should accurately identify patients who are carers so appropriate support can be offered.

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 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 six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people	**Inadequate**
People with long term conditions	**Inadequate**
Families, children and young people	**Inadequate**
Working age people (including those recently retired and students)	**Inadequate**
People whose circumstances may make them vulnerable	**Inadequate**
People experiencing poor mental health (including people with dementia)	**Inadequate**

Summary of findings

Areas for improvement

Action the service MUST take to improve

- The provider must ensure safe care and treatment is provided.
- The provider must ensure patients are safeguarded from abuse and improper treatment.
- The provider must have a system in place to ensure all complaints are recorded, investigated and appropriately responded to.
- The provider must improve their governance arrangements.
- The provider must ensure all staff are suitably qualified, skilled, trained and supported.

Action the service SHOULD take to improve

- The provider should accurately identify patients who are carers so appropriate support can be offered.

Dr Ahmed Choudhury

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team also included a GP specialist adviser.

Background to Dr Ahmed Choudhury

Dr Ahmed Choudhury is located on the first floor of a health centre in Oldham Town Centre. There are 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.

There are two male GP partners (total full time equivalent one GP) and at times they are supported by locum GPs. There are two part time locum advanced nurse practitioners, two part time practice nurses, a practice manager and administrative staff.

The practice has 2925 patients registered. It is a member of NHS Oldham clinical commissioning group (CCG) and delivers commissioned services under the General Medical Services contract.

The practice is open 8am until 6.30pm Monday to Friday. Appointment times are 8am until 11.30am and 2.30pm until 5pm.

The practice is in the second most deprived area on the deprivation scale, where one is most deprived and 10 least. Life expectancy is 76 for males (below the national average of 79) and 80 for females (below the national average of 83). There is an above average number of patients with a long term condition (65% compared to the CCG average of 56% and the national average of 53%).

There is an out of hours service available by phoning NHS 111. The out of hours provider is Go To Doc Limited.

Inadequate

Are services safe?

Our findings

We rated the practice, and all of the population groups, as inadequate for providing safe services.

Safety systems and processes

The practice did not have clear systems to keep patients safe and safeguarded from abuse.

- The practice had a suite of safety policies, and those we requested had been reviewed. However, policies were not always followed, for example the safeguarding children and young people policy. The practice manager told us there was no written guidance about reporting significant events, but staff told us they thought there was a policy available on the practice's shared drive. Following the inspection the practice sent us their significant event toolkit, updated 11 December 2017, that gave guidance to staff.
- The practice did not have adequate systems to safeguard children and vulnerable adults from abuse. GPs told us they did not attend any formal safeguarding meetings. There was no system in place to follow up children who did not attend appointments. We saw an example where the practice had been told a baby had child protection issues. They had been given an appointment for the eight week check and did not attend. This was not followed up for two weeks. An appointment was made for another child to have an urgent on the day appointment. They did not attend and this was not followed up. We also saw an example of a looked after child with no record of who had parental responsibility, and a looked after child where coding errors meant the family situation was unclear. Following the inspection the practice sent us an assurance that they would follow set procedures and follow up children who did not attend appointments.
- The practice carried out staff checks, but these were not always in line with their policies. For example, the safeguarding children and young people policy stated all staff must have a face to face interview, two references, a Disclosure and Barring Service (DBS) check and all gaps in their employment history checked. (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). Evidence of clinicians having medical indemnity insurance was kept, but the evidence held for a locum GP showed theirs had expired at the end of November 2017. The practice manager confirmed they were working at the practice on the day of the inspection. The recruitment policy was brief and did not include information on relevant checks that were required.
- Not all staff had received appropriate training in safeguarding. One practice nurse had not been trained in safeguarding children, and there was only evidence of the other practice nurse having level one training in safeguarding children, instead of the required level two. The deputy practice manager had received no training in safeguarding vulnerable adults or children. The safeguarding policy stated staff should have annual training. One week after the inspection the practice manager told us one practice nurse had since completed level three training. They told us they were waiting for information about training for the other practice nurse.
- Not all staff who acted as chaperones had received a DBS check. The practice manager told us they had not carried out a risk assessment to determine if a DBS check was appropriate for staff. Following the inspection the practice manager told us they had requested a DBS check for all staff.
- There was a system to manage infection prevention and control. An infection control audit had been appropriately carried out in November 2017. The infection control policy stated all staff would be trained on induction and then annually. There was no record of this occurring. Handwashing training for all staff was carried out until February 2015, but after that only clinicians received updates.
- The practice usually ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. However, we found 24 out of date syringes stored with in-date syringes in a clinical room. One of these had an expiry date of October 2015.

Risks to patients

There were limited systems to assess, monitor and manage risks to patient safety.

Inadequate

Are services safe?

- The GPs had recognised they could not provide the number of appointments required by the clinical commissioning group (CCG) with their staffing levels (one full time equivalent GP). They had recruited locum advanced nurse practitioners in September 2017 as a way of increasing appointment numbers. They had also recruited a new practice nurse in April 2017. However, as the original practice nurse had reduced their hours and the new practice nurse worked part-time the number of available nursing hours had reduced.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention.
- Although there had been changes to staffing levels the impact on the safety of the practice had not been assessed or monitored.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- Individual care records did not always contain the information required to keep patients safe. For example, we saw an example where there was no coding on a patient's records to indicate their child was on the child protection register.
- Care plans for patients were limited. One care plan contained information about the patient's next of kin but no clinical information. There was a plan for the newly recruited advanced nurse practitioners to take over the management of care plans for patients, particularly those at risk of hospital admission.

Safe and appropriate use of medicines

The practice did not have adequate systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines minimised risks.
- The practice kept a record of prescriptions received at the practice, but did not log these in and out. They were left in printers overnight, but clinical rooms were kept locked for safety.
- The practice did not involve patients in regular reviews of their medicines. We checked the medicine reviews for patients prescribed four or more medicines. 19% of these patients had had a medicine review since April 2017. We checked two of the patients who had not been reviewed. These patients had seen a GP but a medicine review had not been carried out at the same time.
- Repeat prescriptions were kept in a box for the GP to sign, or were sent electronically to the pharmacy. Patients were not made aware (for example by highlighting on the prescription) if the prescription was outside the medicine review date.

Track record on safety

- The majority of safety checks were carried out by the building managers. The practice had evidence that these checks and risk assessments, such as for fire or legionella, were in place.
- We saw few examples of practice specific comprehensive risk assessments in relation to safety issues.

Lessons learned and improvements made

The practice did not learn and made improvements when things went wrong.

- There was a system for recording and acting on significant events (SEAs) and incidents, but this was not effective. Five SEAs had been recorded in the 12 months prior to the inspection. The practice manager said they recorded everything that was brought to their attention. However, we saw examples of SEAs that had not been handled correctly and therefore not properly investigated. One of the GPs showed us an SEA relating to documents scanned onto the incorrect patient's records. They had recorded this but not passed this on to be formally recorded by the practice. There was no investigation and it was not checked if any other documents received the same day were scanned onto the correct records. The practice nurse also showed us an example of an SEA they had recorded and kept for the purpose of their appraisal. This had not been forwarded to the practice manager to be properly actioned. SEAs were discussed on an ad hoc basis; meetings between the two partners were rare as they did not work during the same hours. They were in the process of changing meeting arrangements and would meet monthly from 14 December 2017. Reception staff told us how patients with challenging behaviour were

managed. Although the records of patients with challenging behaviour were noted, SEAs were not completed following acts of aggression. There was no annual review of SEAs.

- Systems for reviewing and investigating when things went wrong were not adequate. We saw an example of an SEA from April 2017 when the computer system crashed. One action was for a list of patient appointments to be printed off each night in case the appointment system could not be accessed the following day. GPs told us this was discussed on the day of the SEA but they did not know if it had been discussed since. They did not think appointments were printed off each day. We saw that some incidents were not correctly recorded as an SEA. For example a sample labelling error meant that a child did not receive treatment for an eye infection. This was not recorded as an SEA, was not investigated, and learning points were not considered. We saw that sample labels were printed in the reception area, so GPs taking samples had to walk from their room to reception in order to label samples taken during a consultation, which increased the risk of mis-labelling. Ways to improve this system had not been considered.
- The system for receiving and acting on safety alerts was not adequate. The practice manager told us they should put new guidance and alerts on the practice's shared drive but they had not done this for a while. GPs did not know how new guidance was disseminated to the nurses but we saw evidence that the practice nurse had signed up for alerts and kept up to date with new guidance.
- GPs told us they were aware of Medicines and Healthcare Products Regulatory Agency (MHRA) alerts. We checked action taken following an MHRA alert regarding risks to unborn babies of patients taking Valproate (used primarily to treat epilepsy, bi-polar disorder and prevent migraine headaches). We saw that two patients came into the category of those that could be affected. There was no record of any consultation with them where appropriate advice had been given.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice, and all of the population groups, as inadequate for providing effective services.

Effective needs assessment, care and treatment

The practice did not have adequate systems in place to keep clinicians up to date with current evidence-based practice. The practice manager emailed National Institute for Health and Care Excellence (NICE) updates to GPs who said they had informal chats about new guidance. Although we saw the practice nurses had a system to keep up to date with new guidance this was self-managed and the GPs were not aware of how nurses received guidance. New guidelines were not referenced so there was no evidence of them being received or disseminated. The practice manager told us they were supposed to put new guidance and alerts on the practice's shared drive but they had not done this for a while.

- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) July 2016 to June 2017 was 0.5%. This was below the CCG average of 1.4% and the national average of 1%.
- The number of antibacterial prescription items prescribed per STAR PU July 2016 to June 2017 was 1.3%. This was the same as the CCG average and above the national average of 1%.
- The percentage of antibiotic items prescribed that were Cephalosporins or Quinolones July 2015 to June 2016 was 5%. This was in line with the CCG average of 4% and the national average of 5%.
- We saw no evidence of discrimination when making care and treatment decisions.

Older people:

- Patients aged over 65 were invited for a health check. GPs told us that if necessary they were referred to other services such as voluntary services.
- Older patients had a Rockwood Fragility Score assessment as part of their over 65 health check. This was a way of identifying patients at risk of frailty, then assessing and managing the risk.
- The GPs told us they followed up on older patients discharged from hospital as required. This could be by telephone or visit.
- The practice had recently employed two locum advanced nurse practitioners. It was planned that they would take over responsibility for putting in place and updating care plans. At the time of the inspection there was no overview of patients with a care plan in place.

People with long-term conditions:

- Patients with long-term conditions were usually recalled for an annual review with the practice nurse. The practice told us there had been a recent change to an electronic recall system and some patients had been lost. They were in the process of rectifying this.
- One of the nurses had recently completed an insulin initiation course so patients could receive support locally.
- Performance for diabetes related indicators was 93%. This was above the CCG average of 88% and the national average of 91%.
- Performance for asthma related indicators was 100%. This was above the CCG average of 99% and the national average of 97%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were 97%, which was above the target percentage of 90%.
- The practice did not have arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice did not do all that was required to safeguard children. Not all staff had received appropriate training and systems needed updating to give assurance concerns were responded to.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 81%, which was in line with the 80% coverage target for the national screening programme.

Inadequate

Are services effective?

(for example, treatment is effective)

- Patients were offered health assessments and checks including NHS checks for patients aged 40-74.

People whose circumstances make them vulnerable:

- End of life care was not delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held registers of patients living in vulnerable circumstances including those with a learning disability.

People experiencing poor mental health (including people with dementia):

- Performance for mental health related indicators was 74%. This was below the CCG average of 92% and the national average of 94%.
- The percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 60%. This was below the CCG average of 92% and the national average of 91%.

Monitoring care and treatment

The practice did not have a comprehensive programme of quality improvement activity. It did not routinely review the effectiveness and appropriateness of the care provided. We saw that medicine optimisation audits had been carried out, but GPs could provide us with no evidence of clinical audit or participation in improvement initiatives. Medicine optimisation ensures patients receive the right choice of medicine at the right time to improve their outcomes.

The most recent published Quality Outcome Framework (QOF) results for 2016-17 were 94% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and the national average of 96%. The overall exception reporting rate was 12% compared with the CCG average of 8% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

QOF was monitored by the practice nurse and practice manager. GPs told us they received lists in January, February and March so they could complete any outstanding QOF work. One of the GPs did not know how to access the QOF system to monitor their progress.

Effective staffing

There was not always evidence that staff had the skills, knowledge and experience to carry out their roles. However, nursing staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. We identified issues around some training and support for staff.

- The practice did not understand the learning needs of staff. Although training records were kept we saw that mandatory training had not been completed for all staff. There was no record of training for locum staff. The practice manager explained that they had found training difficult since the CCG stopped the training budget, and they now had to source and fund their training. They found it difficult to allow staff to attend external training as they had a small staff team. However, they said they had recently realised they were able to close for half a day each month and told us this would allow them to pay more attention to the training needs of staff. The practice manager told us they had needed to concentrate on staff learning their job role rather than providing other training.
- We saw that new staff had an induction programme to follow, however it was not always recorded that this had been completed. The practice manager told us they appraised non-clinical staff annually. GPs carried out the appraisals for the practice manager and nurses. We saw evidence that the practice manager had an appraisal 24 November 2017, but saw no evidence of any other appraisal since March 2007. The practice did not keep a copy of the nurse's appraisal for monitoring purposes; the practice nurse kept this for their records. Evidence of appraisals was not available for all other staff. The practice manager explained that the deputy manager appraised two staff in December 2016. They were unable to locate these records as the deputy manager was off work.

Coordinating care and treatment

Inadequate

Are services effective?

(for example, treatment is effective)

We did not see evidence of staff working together with other health and social care professionals to deliver effective care and treatment.

- The practice had recently employed two locum advanced nurse practitioners. It was planned that they would take over the responsibility of contacting and monitoring patients who were discharged from hospital. They would also put care plans in place for these patients, and patients at risk of hospital admission, then monitor and update these care plans. On the day of the inspection this had not started.
- The practice could not provide evidence that end of life care was delivered in a coordinated way which took into account the needs of different patients. We saw that care plans were in place for some terminally ill patients. GPs told us they recorded patients' preferred place of care but they did not audit this to see if their wishes had been acted on. We saw an example of the GP speaking with the family of a terminally ill patient. However, they were not coded as receiving palliative care and there was no alert regarding a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) that was in place.
- The practice did not have routine multi-disciplinary team meetings to discuss end of life care. Meeting minutes showed that they were planning to reinstate cancer care meetings, but we saw no evidence these had been arranged.

Helping patients to live healthier lives

We did not see evidence of staff proactively helping patients to live healthier lives.

- Patients in the last 12 months of their lives did not always have a care plan which identified and monitored their needs. Carers were not offered additional support.
- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway April 2015 to March 2016 was 53%. This was comparable to the CCG average of 57% and the national average of 50%.
- The practice referred patients to local agencies for help with smoking cessation or weight management.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The chaperone policy was displayed in of clinical rooms. However, there was no notice to clearly inform patients a chaperone was available if required.
- All of the 28 patient Care Quality Commission comment cards we received were positive about the service experienced.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 332 surveys were sent out and 135 were returned. This represented about 5% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 95% of patients who responded said the GP gave them enough time; CCG - 86%; national average - 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 88% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 86%; national average - 86%.
- 96% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 97% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 86% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care:

- Interpretation services were available for patients who did not have English as a first language. The two partners both spoken other languages including Bengali, Urdu and Hindi.
- Staff told us easy read materials were available.
- The practice manager told us patients were directed to other services in the area if this was appropriate.

The practice had identified that 17 patients (0.6% of the patient list) were carers. One of the GPs did not know if there was a carers' register. The practice manager told us they used to issue carers with an information pack but stopped doing this because they did not know what facilities were available in the Oldham area. The practice manager told us carers were offered a flu vaccination but carers' health checks were not offered. No further support was provided for carers.

Staff told us there were no formal arrangements to follow if a family suffered a bereavement. The practice manager was unsure what counselling services were in the area.

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:

Requires improvement

Are services caring?

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 81%; national average - 82%.
- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 97% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice did not always organise and deliver services to meet patients' needs.

- The facilities and premises were appropriate for the services delivered.
- The practice made some adjustments when patients found it hard to access services, for example by providing longer appointments.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was not always coordinated with other services. The practice was planning to re-introduce cancer care meetings but these had not yet commenced.
- The practice did not offer extended opening hours. However, within the clinical commissioning group (CCG) area patients could access appointments until 8pm on weekdays and during the day at weekends.

Older people:

- All patients had a named GP.
- The practice had recently employed two locum advanced nurse practitioners. It was planned that the advanced nurse practitioners would carry out care home visits and manage care plans, although this had not started at the time of the inspection.
- The practice carried out home visits and offered urgent apointments, but had recognised there were staffing capacity issues in the practice.

People with long-term conditions:

- Most patients with a long-term condition received an annual review to check their health needs were being appropriately met. It had been found that some patients had been missed when the recall system recently changed.
- Patients prescribed multiple medicines did not always receive a timely medicines review. Only 19% of patients prescribed four or more medicines had a review since April 2017.
- Due to time constraints regular formal meetings with the local district nursing team did not occur.

Families, children and young people:

- We found systems to identify and follow up children living in disadvantaged circumstances or who were at risk were not adequate. Records showed possible situations where children could be at risk had not been identified. .
- Parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice registered patients from out of the area to make it easier for working patients to see a GP.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- When a vulnerable patient attended for an appointment the GP went to the waiting area to call them rather than relying on the speaker system.
- Not all staff had received training in safeguarding, and when delivered not all training was to the appropriate level.

People experiencing poor mental health (including people with dementia):

- Some staff had received dementia training.
- GPs told us they had a register of patients with dementia and that most patients with dementia were reviewed by the memory nurse who attended the practice or patients' homes when required.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients told us they had timely access to appointments at the practice.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Some patients told us there could be delays to them being seen when they were at the practice.
- The appointment system was easy to use.
- We looked at available appointments for the day after the inspection. We saw that nine of the book on the day appointments had been filled.
- The two GP partners had recognised that they were unable to provide the number of appointments required within their working hours (one full time equivalent post). They had very recruited two part time locum advanced nurse practitioners and were also in the process of making changes to the partnership to address the issue.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. 332 surveys were sent out and 135 were returned. This represented about 5% of the practice population.

- 73% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 73% of patients who responded said they could get through easily to the practice by phone; CCG – 73%; national average - 71%.
- 82% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 81%; national average - 84%.
- 83% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 71%.
- 78% of patients who responded described their experience of making an appointment as good; CCG - 72%; national average - 73%.
- 61% of patients who responded said they don't normally have to wait too long to be seen; CCG - 59%; national average - 58%.

Listening and learning from concerns and complaints

The practice did not take complaints and concerns seriously and did not respond to them appropriately with a view to improving the quality of care.

- Information about how to make a complaint or raise concerns was available.
- The complaint policy and procedures were mainly in line with recognised guidance. However, the complaints leaflet referred to the NHS Commissioning Board. This has not existed since April 2013 when NHS England was formed.
- The practice manager told us they had only received one complaint (a verbal complaint) between October 2016 and November 2017. The GPs told us they had only received two complaints in the previous six years. However, we saw evidence of a written complaint that had been received in the previous 12 months. There was no record of this in the complaints file, we did not see any evidence that a response to the complaint had been provided, and we saw no evidence of learning from the complaint being monitored.
- We saw that a written response had been given to the verbal complaint that had been recorded. The response contained an apology but information provided in the response was inappropriate. For example, it named the staff member the practice manager had identified as being at fault and gave personal information about that staff member.
- There was no review of complaints to check learning had been embedded.

Are services well-led?

Inadequate

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

Our findings

We rated the practice as inadequate for providing well-led services.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- We saw no evidence that leaders had identified risks in the practice, so risks had not been addressed.
- They were not knowledgeable about issues and priorities relating to the quality and future of services.
- The practice did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The two GP partners worked at different times, providing one full time equivalent GP post, so formal communication was poor between them. They told us they did chat on the telephone and as both GPs worked as locum GPs for other practices in the building they did see each other informally. The two practice nurses also worked at different times.
- Staff told us leaders were visible and approachable. However, as partners did not attend the practice at the same time leadership was not structured or coordinated.

Vision and strategy

The practice had a new strategy within the practice to improve outcomes for patients:

- The partners told us although the practice would continue to be run as a separate legal entity with its own CQC registration, another practice would be taking them over so administration would change.
- Two partners from the other practice were joining the practice of Dr Ahmed Choudhury. The practice manager of the other practice would become the business manager for both practices, setting up shared governance procedures. The practice manager would continue in their role at the practice. The two current partners then planned to leave as partners, but would continue to be locum GPs at the practice.
- It was envisaged that having shared governance, which would include joint clinical and administrative meetings from December 2017, would improve the performance of all aspects of the practice.

Culture

The practice did not have a culture of high-quality sustainable care.

- Openness, honesty and transparency were not always demonstrated when responding to incidents and complaints. Not all incidents or complaints were appropriately recorded and therefore not appropriately responded to.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. However although there was an awareness of the duty of candour we saw that when things went wrong patients and other people affected were not always informed. The records we saw made it difficult to see how issues such as complaints were being effectively managed.
- Staff development was not a priority. The practice manager explained that it was difficult to allow staff to attend training courses due to the financial cost and the fact that the small practice team meant it was sometimes difficult for cover to be provided.
- The practice manager told us all staff had annual appraisals. Evidence of this was not available for all staff. In addition, although the practice manager had an appraisal during the two weeks prior to our inspection, there was no evidence of another appraisal for over 10 years.
- There was not a strong emphasis on the safety and well-being of all staff. We heard an example of patient who displayed challenging behaviour towards reception staff and equipment. Although the patient's records were annotated a significant event had not been raised and there was no risk assessment to ensure further episodes of challenging behaviour were managed safely.
- Staff told us they felt respected, supported and valued. However, we saw the response to the one complaint

Are services well-led?

Inadequate

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

that had been recorded since October 2016. This went into detail about the staff member who had been identified as being at fault and it demonstrated a blame-like culture.

Governance arrangements

The systems of accountability in place to support good governance and management were not effective.

- The governance and management of the partnership did not promote interactive and co-ordinated person-centred care. Communication between the partners and other clinicians was poor due to working arrangements. Clinicians did not have the opportunity to meet often so had to rely on notes and telephone calls to promote continuity of care. Evidence of this was not kept.
- Although staff told us they were clear on their roles and accountabilities, including in respect of safeguarding, evidence seen did not demonstrate this. GPs had not recognised where child safeguarding could have been compromised so appropriate action had not been taken.
- Staff meetings, for clinicians and administrative staff, had been infrequent and without a set agenda. We saw evidence that meetings would be held monthly in the future. The practice manager told us until now they had not realised they had been able to close for half a day a month so that meetings and training could take place.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However not all policies and procedures were fit for purpose and information was not always cascaded to staff. When meetings had taken place staff who did not attend were not aware of minutes being available so they could see what had been discussed.

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Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

- The partners had not previously identified the issues and breaches of regulation found during the inspection. The process to identify, understand, monitor and address current and future risks including risks to patient safety was therefore ineffective.
- The practice did not have processes to manage current and future performance. There was no audit of the consultations of clinicians, including locum GPs and locum advanced nurse practitioner.
- The practice manager gave us a written statement dated 23 November 2017 saying that they had received the GP patient survey results, released in July 2017, and would discuss them at a meeting 14 December 2017. However during the inspection we were provided with meeting minutes from 23 November 2017. These minutes were very brief and stated the results had been discussed and the nurse, who was not noted as being present at the meeting, had been congratulated. There was no action plan recorded and no record of a discussion around any improvements that could be made.
- Although the clinical commissioning group (CCG) pharmacist carried out medicines audits we saw no evidence of clinical audit in the practice.

Appropriate and accurate information

We saw little evidence of the practice acting on appropriate and accurate information.

- Quality and sustainability were not regularly discussed as meetings were infrequent. Meeting minutes did not always provide full information about what had been discussed.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice did not use information technology systems to monitor and improve the quality of care. Coding on patients' records was not always accurate, and where systems could be used, for example to monitor the availability of appointments, this had not been identified.

Are services well-led?

Inadequate

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

- The practice submitted data or notifications to external organisations when required. However our inspection found that not all relevant information, such as for significant events, was recorded and so this was not appropriately submitted.
- The practice took data security standards seriously so patient identifiable data was kept securely.

Engagement with patients, the public, staff and external partners

The practice did not actively involve patients, staff or external partners to support high-quality sustainable services.

- Meetings were not frequent or structured so a diverse range of staff and external partners' views and concerns were not encouraged, heard and acted on to shape services and culture.
- The practice manager told us they had tried to form a patient participation group (PPG) but this had not been successful. They had then identified seven patients who were interested in joining a virtual PPG. They had sought their opinion about the ordering of repeat prescriptions in February 2016, but had not contacted them since.

Continuous improvement and innovation

Systems and processes for learning, continuous improvement and innovation were not effective.

- There was no focus on continuous learning and improvement at all levels within the practice. Training was not a priority and the practice manager explained they had to concentrate on training required as part of the job. Training for one of the nurses, advanced nurse practitioners and locum GPs was not monitored or recorded.
- The practice did not make use of internal and external reviews of incidents and complaints. Significant events and complaints were not appropriately reviewed or investigated and learning was not shared or used to make improvements.
- Leaders and managers did not encourage staff to take time out to review individual and team objectives, processes and performance.
- The practice was in the process of changing their governance arrangements. There would be a change in the partnership and the governance structure would be shared with another practice. The current partners had identified that the practice in its current format was not sustainable.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have an assurance that all clinicians had received appropriate relevant training. Safeguarding training had not been provided to all staff and some clinicians were not trained to the appropriate level. Mandatory and other training had not been well-monitored. External training was rarely attended as staff cover was not available. Appraisals had been carried out but this had not been completed regularly and there was no evidence of appraisal held for some staff. This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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 The registered person did not operate an effective system to deal new guidance or safety alerts. Medicine reviews were not carried out at regular intervals and not all patients were recalled for a review of their long term condition. Repeat prescriptions were issued without checking this was appropriate. Some care plans were in place but there was no system to ensure they contained relevant up to date information. Not all pathology reports were actioned to ensure treatment was provided. Not all equipment was within its expiry date. There was no adequate system to ensure all babies received checks at the correct time. Carers and bereaved patients were not routinely provided with support. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not carry out recruitment checks identified as essential in their safeguarding policy. There was no policy in place for when children did not attend appointments and these cases were not always followed up. Coding of patients where there could be safeguarding issues was not always accurate. There was little understanding of the responsibilities of the practice when patients were looked after children or on the child protection register. This was in breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person did not record all complaints, including written complaints, brought to their attention, so not all complaints were investigated. Inappropriate responses were given to some complaints. The complaints' policy contained out of date information. This was in breach of regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not record and investigate all significant events so improvements and learning was not identified. Clinical audits were not taking place. Other audits and checks as a way of improving the service had not been considered. The system for checking equipment was within their expiry date was not effective. Communication was poor and meetings were infrequent and not well minuted so the governance of the practice was not well understood. The process for ensuring all clinicians had up to date indemnity insurance was not effective. Feedback from patients was not routinely sought. The practice had decided not to have Disclosure and Barring Service (DBS) checks for chaperones but had no risk assessments in place regarding this. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.