The Old Forge Surgery

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?	Inadequate
Are services caring?	Good
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

We carried out a comprehensive inspection of The Old Forge Surgery on 21 April 2015.

Overall, we rated the practice as inadequate. Specifically, we found that the practice was inadequate for providing safe, effective and well led services, but was good for providing caring services. The practice needed to make improvements to ensure that services were responsive to the needs of its population.

Our key findings were as follows:

- Patients' needs were assessed but care was not always delivered following best practice guidance;
- The outcomes of patients' care and treatment were not regularly monitored;
- The practice did not have a clear vision or strategy. Although the practice had a management team, there was a lack of effective leadership;
- When things went wrong, reviews and investigations were not sufficiently thorough and lessons learned were not communicated widely enough to support improvement;
- There were ineffective systems in place for infection control and monitoring patients' medicines;
- Staff had not received the training necessary to carry out their roles effectively
- Feedback from patients was generally positive; they told us that staff treated them with respect and kindness;
- Patients generally reported good access to the practice, with urgent appointments available the same day, although we observed some patients waited a long time once they arrived for their appointment;
- Staff felt supported by the management team.

There were several areas of practice where the provider needs to make improvements.

Importantly, the provider must:

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- Ensure that there are formal governance arrangements in place, including systems for assessing and monitoring the quality of the service provision. Staff must have appropriate policies and guidance to carry out their roles in a safe and effective manner.
- Ensure that audits of practice are undertaken, including completed clinical audit cycles.
- Take action to ensure that effective infection control systems are in place.
- Ensure relevant checks are carried out on staff, in relation to recruitment of new staff and the professional registrations of existing staff.
- Implement systems to ensure that patients' medicines are effectively monitored and take action to ensure that blank prescription forms are handled safely.
- Provide appropriate training for all staff, including training on fire safety and information governance.

It has come to my attention also that two of the three GP partners are on sick leave, so I am asking the provider to supply us with information through a section 64 letter about how the practice will cover the appointments needed to meet the needs of its patient population during this time.

On the basis of the ratings given to this practice at this inspection, and the continual breaches of regulations identified at two previous inspections, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

The practice had arrangements in place to manage emergencies. We saw records which showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency).

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learned were not communicated widely enough to relevant staff to support improvement.

Patients were at risk of harm because systems and processes to keep them safe were not in place. Areas of concern included the lack action that was required with regards to infection prevention and control, and the fact that no Disclosure and Barring Service (DBS) checks were completed for any staff other than the GPs. There were also ineffective systems in place for monitoring patients' medicines.

Are services effective?

Inadequate

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

There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the equipment that they needed to deliver effective care and treatment. Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision-making and choices about their treatment.

However, the outcomes of patients' care and treatment were not regularly monitored. Some patients' prescriptions were not reviewed in line with published guidance. We found the practice was not completing effective clinical audits.

Nationally reported data taken from the voluntary Quality and Outcomes Framework (QOF) for 2013/14 showed that the practice had achieved a below average number of points (with an overall score of 71.4%, compared to 94.5% locally and 93.7% nationally) for the majority of the 20 clinical conditions covered. For a number of indicators the practice was performing well below the levels of other practices, both locally and nationally.

Summary of findings

The local clinical commissioning group (CCG) and NHS England had raised concerns about the practice's performance and had asked the practice in January 2015 to prepare a formal action plan to show how it was going to improve. At the time of the inspection this plan had not been developed; staff told us they were waiting for assistance from the CCG.

The majority of staff had received an appraisal, but not all staff had attended mandatory training, including information governance and fire safety.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect. Patient's privacy and confidentiality was respected. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect.

Data showed that patients rated the practice much higher than others for several aspects of care, especially in relation to the nursing staff. For example, 86% said the last nurse they saw or spoke to was good at involving them in decisions about their care (compared to the national average 67%).

Are services responsive to people's needs?

Requires improvement

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

The majority of patients we spoke with, and those who completed CQC comment cards said they felt the practice was meeting their needs. For example, patients could make appointments for a face-to-face consultation in the practice, they could receive a telephone call back from a clinician or be visited at home.

Findings from the National GP Patient Survey, published in January 2015, showed that most patients were satisfied with practice's opening hours, telephone access, and availability of appointments. For example, of the patients who responded to the survey, 89% said they were satisfied with the practice's opening hours. This was above the local CCG average (81%) and national average (76%).

The practice offered an annual check of health and wellbeing for patients with long-term conditions, such as asthma and diabetes, and this was offered more often if the nursing team judged it necessary. However, nationally reported data showed that patient

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outcomes were below the local clinical commissioning group (CCG) and national averages. For example, only 54% of patients on the asthma register had had an asthma review in the preceding 12 months (this was 22% below the local and national average).

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

Staff told us that they felt valued, well supported and knew who to approach in the practice with any concerns. The practice sought feedback from patients and had an active patient participation group (PPG).

The practice did not have a clear vision or strategy. The practice had a management team but there was a lack of effective leadership. There were no clear priorities or a development strategy for the leadership of the practice.

There was a lack of any identifiable governance structure throughout the practice. The practice did not have all in place all the required policies and procedures to govern activity. It was evident that the lack of formal guidelines resulted in inconsistencies in staff's practice. There was little innovation or service development.

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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. This is because the practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for responsive services, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that the practice had good outcomes for conditions commonly found among older people. The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 to inform them who their named GP was. The practice was responsive to the needs of older people, and offered home visits for health checks and flu vaccinations. The percentage of patients aged over 65 who had received a seasonal flu vaccination was slightly above the overall average for other practices nationally (74% compared to national average of 73%).

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. This is because the practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for responsive services, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

The practice nursing team was responsible for delivering most of the care and treatment that patients needed for chronic diseases. The practice offered an annual check of health and wellbeing for patients with long-term conditions, such as asthma and diabetes, and this was offered more often if the nursing team judged it necessary. However, the Quality and Outcomes Framework (QOF) data (2013/14) showed that a significant number of patients had not received a review. For example, only 54% of patients on the asthma register had had an asthma review in the preceding 12 months (this was 22% below the local and national averages).

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. This is because the practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for responsive services, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

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Systems were in place to identify and follow-up children who were considered to be at risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings, which involved child care professionals such as school nurses and health visitors.

Appointments were available outside of school hours and reception staff had been trained to take note of any urgent problems and notify the doctor about an unwell child or parental concern. The premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for 12-month and 24-month old babies and five-year-old children were in line with the local CCG area.

Pregnant women were able to access an antenatal clinic provided by healthcare staff who were attached to the practice. The practice had obtained 100% of the QOF points available for providing recommended maternity services. Nationally reported QOF data (2013/14) showed that antenatal care and screening were offered in line with current local guidelines. However, the data also showed that child development checks were not offered at intervals consistent with national guidelines.

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). This is because the practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for responsive services, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

The practice had identified the needs of the working age population, those recently retired and students It had adjusted its services to ensure they were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening, which reflected the needs of this age group.

Patients could order repeat prescriptions and book appointments on-line. The practice was open between 7:30am and 6pm all weekdays except Thursday, when it was open from 8am until 6pm.

We saw that health promotion material was made easily accessible through the practice's website. This included how to find other sources of information and links to other websites including those dedicated to 'living well'. The practice provided additional services such as smoking cessation advice clinics, travel vaccinations and minor surgery. However, the QOF (2013/14) data showed the

Summary of findings

practice had not supported patients to stop smoking. The data showed that the practice had only obtained 53.8% of the points available for providing support with smoking cessation. This was 40.4 percentage points below the local CCG average and 39.9 points below the England average.

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. This is because the practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for responsive services, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Systems were in in place to identify patients, families and children who were at risk or vulnerable. The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. However, nationally reported data (QOF 2013/2014) showed that the practice had only achieved four out of the seven points available for the learning disability clinical domain.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The practice had a policy of expecting the patient to enquire about the results of their tests such as minor surgery, but there was no policy of communicating results to those who may not have been able to enquire for themselves.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). This is because the practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for responsive services, and the concerns that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported QOF data (2013/14) showed that the practice had not achieved good outcomes for all its patients who were experiencing poor mental health. For example, the practice had only obtained 53.5% of the points available for providing recommended care and treatment for patients with mental health needs. This was

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36.8 percentage points below the local CCG average and 36.9 points below the England average. Although the practice kept a register of patients with mental health needs, the QOF results showed that not all patients received relevant checks and tests.

The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had care plans in place for patients with dementia. Patients experiencing poor mental health were told how they could contact various support groups and third sector organisations.

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What people who use the service say

We spoke with 13 patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

We reviewed 18 CQC comment cards which had been completed by patients prior to our inspection.

Most of the patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us that they were treated with respect and dignity at all times and they found the premises to be clean and tidy.

The latest National GP Patient Survey published in January 2015 showed that the large majority of patients were satisfied with the services the practice offered. Many of the results were well above the national average:

- GP Patient Survey score for opening hours – 89% (national average 76%)
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 91% (national average 71%)
- Percentage of patients rating their experience of making an appointment as good or very good – 79% (national average 73%)
- Percentage of patients rating their practice as good or very good – 92% (national average 86%)
- The proportion of patients who would recommend their GP surgery – 84% (national average 78%).

Areas for improvement

Action the service MUST take to improve

- Ensure that there are formal governance arrangements in place, including systems for assessing and monitoring the quality of the service provision. Staff must have appropriate policies and guidance to carry out their roles in a safe and effective manner.
- Ensure that audits of practice are undertaken, including completed clinical audit cycles.
- Take action to ensure that effective infection control systems are in place.
- Ensure relevant checks are carried out on staff, in relation to recruitment of new staff and the professional registrations of existing staff.
- Implement systems to ensure that patients' medicines are effectively monitored and take action to ensure that blank prescription forms are handled safely.
- Provide appropriate training for all staff, including training on fire safety and information governance.

Action the service SHOULD take to improve

- Take steps to implement a formal complaints policy, in line with recognised guidance and contractual obligations for GPs in England.

The Old Forge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP, a practice nurse and a specialist advisor with experience of GP practice management.

Background to The Old Forge Surgery

The Old Forge Surgery is registered with the Care Quality Commission to provide primary care services. It is located in the Pallion area of Sunderland.

The practice provides services to around 8,000 patients from one location - Pallion Park, Pallion, Sunderland, SR4 6QE. We visited this address as part of the inspection. The practice has three GP partners, two salaried GPs, two practice nurses, a healthcare assistant, a practice manager, and 12 staff who carry out reception and administrative duties.

The practice is part of Sunderland Clinical Commissioning Group (CCG). The practice is situated in an area where there are pockets of high deprivation. The practice population is made up of a higher than average proportion of patients between the ages of 45 and 84.

The practice is located in a purpose-built single storey building. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

Surgery opening times at the practice are between 7:30am and 6pm every week day, except Thursday when the practice is open between 8am and 6pm (the practice has a local agreement where the local out of hours service provides cover between 6pm and 6:30pm). Patients can book appointments in person, on-line or by telephone.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

Services for patients requiring urgent medical attention out of hours are provided by the 111 service and Primecare.

Why we carried out this inspection

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

We had previously inspected the practice in October 2013 and found the provider had breached Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting Workers (equivalent to Regulation 18 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing). We told the provider to take action to become compliant with the regulation.

Detailed findings

We carried out a further inspection in June 2014 to check whether improvements had been made. The provider had made some progress but remained in breach of the regulation. We told the provider again to take action to become complaint.

During this inspection we found that the practice had taken some action but it was still in breach of the regulation.

How we carried out this inspection

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

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

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

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local clinical commissioning group (CCG), Sunderland clinical commissioning group.

We carried out an announced visit on 21 April 2015. We spoke with 13 patients and 10 members of staff from the practice. We spoke with and interviewed two GPs, the practice manager, three members of the nursing team and four staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 18 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Inadequate

Are services safe?

Our findings

Safe track record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. We (CQC) had not received any safeguarding or whistleblowing concerns regarding patients who used the practice.

The practice used the CCG-wide Safeguard Incident Reporting Management System (SIRMS) to record incidents and provide feedback on patients' experiences of care within other services in the local area.

We saw that records were kept of some significant events and incidents. When asked to give an example of a significant event, we were told about an incident which had occurred in relation to a patient's contraceptive medicines. We asked the practice manager about this but they were not aware of the incident and no written practice records were held. The lack of records showed that the practice had not managed these consistently over time and so could not demonstrate a safe track record.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events, although this was not always effectively implemented.

We spoke with the practice manager about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events. Staff including receptionists, administrators and nursing staff, were aware of the system for raising issues.

Records of incidents were kept on the practice computer system and made available to us. We found that some of the records were incomplete. For example, there was no evidence that some of the reported events had been reviewed. We looked at a sample of 14 records. Of these, eight had not been reviewed to establish whether any changes made to policies and practice had been effective. There was little evidence of learning from events being shared with non-clinical staff or the patients involved.

We saw that there had been a significant event in relation to eight patients who had not been referred to secondary care (other health care services) when they should have been. It was however difficult to clarify what changes were made to ensure this did not happen again. The suggested changes were ambiguous and gave staff options as to which action to take. We could not see how the practice had used these events to learn from the mistakes, in order to ensure they did not reoccur.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. Any alerts were initially received by the practice manager; information was then forwarded to clinicians and other staff where necessary. However, there was no recorded evidence to show that alerts were discussed at the appropriate meetings to ensure all relevant staff were aware of any necessary actions.

Reliable safety systems and processes including safeguarding

The lead GP was the practice lead for safeguarding vulnerable adults and children and they had been trained to child safeguarding Level 3 to enable them to fulfil this role. The staff we spoke with were aware of who the lead for the practice was.

Practice training records showed that staff had received training on safeguarding children. All of the GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Nurses at the practice had completed Level 1 training. Arrangements had been made for nursing staff to complete Level 3 training imminently. All other staff had attended Level 1 training sessions. This was confirmed by the staff we spoke with.

There were no records to demonstrate that any of the GPs had completed any training on safeguarding vulnerable adults. Some nursing and administrative staff had carried out some on line training, but not the whole team. The practice manager showed us the training matrix; there were no planned dates for the GPs to undertake this training, which was available online.

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out).

The practice had a chaperone policy. We saw posters on display in the consultation rooms to inform patients of their

right to request a chaperone. Staff told us that a practice nurse or a member of the administration team undertook this role. The practice training matrix showed that only one member of the administration team staff had undertaken any chaperone training, although staff we spoke with were clear about the requirements of the role. However, none had undergone Disclosure and Barring Service (DBS) checks. There were no risk assessments in place to assess the different responsibilities and activities of staff to determine if they were eligible for a DBS check.

The practice had a whistleblowing policy in place. It was not clear when this had been developed or implemented and the staff we spoke with were not aware it. Staff told us that they would report any concerns to their line manager or a GP partner but they were not clear about what action the practice would then take.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw that medicines were in date and good systems to check expiry dates were implemented.

Some medicines (vaccines) needed to be stored in a refrigerator. Staff confirmed that the procedure was to check the refrigerator temperature every day to ensure the vaccines were stored at the correct temperature. We saw records of the temperature recordings, which showed that the correct temperatures for storage were maintained. However, staff told us the checks were not always carried out on a Friday because there were no nurses working on those days. Staff told us they would put arrangements in place to ensure these checks were carried out daily.

Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). These provide specific guidance on the administration of medicines authorising nurses to administer them. We saw that each nurse held up-to-date copies of the directions.

All new prescriptions were reviewed and signed by a GP before they were given to the patient. However, the systems for monitoring patients' medicines were ineffective and repeat prescriptions were not closely monitored. One of the GPs we spoke with told us some reviews were overdue. They said there was no repeat prescription protocol to follow and no agreed limit for how many repeat prescriptions could be issued if a patient did not attend for a review. The practice was therefore unable to demonstrate that patients' repeat prescriptions were still appropriate and necessary.

The arrangements for making changes to patients' medicines on receipt of hospital discharge letters were not clear. Each letter received was passed to one of the GPs. The administrative staff told us that a GP should then sign to say that they had seen the letter and indicate if the patient's prescription needed to be changed. We looked at a sample of letters; not all had been signed, and some just had the word 'script' noted. There was no system to ensure that the GPs checked that these changes to patients' medicines records were made correctly.

One of the letters related to an increased dosage of a medicine. National guidance suggested that if this medicine was to be increased then the GP should have carried out a blood test. We noted that the GP had not instructed the administrative staff to call the patient in for this blood test.

The monitoring of blank prescription forms was not effective as the serial numbers were not recorded when they arrived into the practice or when the forms were issued to the GPs. This is contrary to guidance issued by NHS Protect.

Cleanliness and infection control

The practice was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

One of the practice nurses was the nominated infection control lead. The practice did not have an up-to-date infection control policy. We asked to see the policy and were shown a document which related to NHS South of Tyne and Wear, which was dated 2009. We were also given the infection control protocols, but this was a brief four-page document and there was no detailed guidance for staff about specific issues, for example, hand hygiene and use of protective clothing.

The infection control protocol stated that new staff would receive infection control training as part of their induction to the practice and that refresher training would then be carried out at least once annually. We saw records which confirmed that the practice manager and the nurses had completed a training course on infection control (in

October 2014 and April 2015 respectively). They had planned to cascade this training to remaining staff. We were told this had not been arranged, as the other staff were to complete an infection control e-learning session prior to this.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. We saw that a spillage kit was available (this is a specialist kit to clear any spillages of blood or other bodily fluid). The privacy curtains in the consultation rooms were disposable and were changed every six months or more frequently if necessary.

The arrangements for the safe disposal of clinical waste and sharps, such as needles and blades were not effective. We looked at some of the practice's sharps bins located in the consultation rooms. Only some of the sharps bins we saw had been signed and dated as required, to show who had constructed them and that they were safe to use.

There were some arrangements for ensuring staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They told us there were bags for patients to put their own specimens in. The nursing staff then wore PPE when transferring the specimens for testing.

We asked the practice manager if the staff were up to date with their immunisations against infectious diseases. They did not hold any records to show whether staff were immunised. We had raised this issue when we previously inspected the practice in October 2013. We stated "the provider may wish to note that there were no records of staff being offered these vaccines or signing a disclaimer to say they did not want to be vaccinated". An infection control audit carried out by one of the practice nurses in November 2014 had identified that some of the administration staff "require risk assessment for Hepatitis B immunisation". The action recorded was to "identify occupational health provider to deliver assessment and immunisation".

The practice manager was unable to demonstrate whether any progress had been made in the 18 months since the previous CQC inspection. It is recommended that individuals at continuing risk of infection should be offered a single booster dose of vaccine, once only, around five years after primary immunisation and a blood test. It was not clear that all staff who were at continuing risk of infection had received this.

The same infection control audit, in November 2014, had also identified that the flooring in one of the treatment rooms was unsuitable. The action stated on the review was "washable flooring required". During our inspection we saw that the flooring in that treatment room had not been replaced. We asked the practice manager for an update on whether this had been arranged. They told us they "needed to find a company to do the work" but as yet had not placed an order.

The practice manager confirmed that a legionella risk assessment had not been completed (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal).

Equipment

The staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment.

Minor surgery was carried out at the practice. We saw there were appropriate arrangements for the disposal of single-use surgical instruments.

Staffing and recruitment

The practice had an up-to-date recruitment policy in place that outlined the process for appointing staff.

We looked at the personnel files for two new members of staff. We found that some of the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) 2010 was not available. For example, there was no evidence that references been taken up for either person. The practice could therefore not demonstrate that they had attempted to assess whether a person was of good character for the role they applied for.

Inadequate

Are services safe?

All of the GPs had undergone DBS checks as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to can carry out status checks on their certificate. However, the practice could not provide sufficient evidence of seeking appropriate assurances from NHS England that such checks had been undertaken. None of the other staff, including all staff who were in contact with patients had been subject to DBS checks.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)). They told us they checked with the GMC and NMC that any new members of staff were registered. However, there were no regular checks to provide assurance of the continuing registration of staff. The practice manager said they did not think this would be good use of their time.

We saw that there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. However, some of the staff we spoke with told us they didn't think there were enough members of staff at the practice. The practice manager told us that in order to work the way the practice wanted to, they needed to recruit another nurse.

Administrative staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, by helping colleagues working on the front reception desk receiving patients or by answering the telephones.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment and equipment. However, many of these checks were informal and any findings and subsequent actions were not recorded.

The practice manager showed us a number of risk assessments which had been developed and undertaken, including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure that the practice was aware of any potential risks to patients, staff and visitors and to plan mitigating action to reduce the probability of harm.

The practice did not regularly monitor the number of extra urgent appointments used to ensure that staffing levels were sufficient to meet demands.

Reception staff had been trained to take note of any urgent problems and to notify the doctor for example, of an unwell child or parental concern.

The practice had some systems in place to manage and monitor health and safety. The fire alarms and emergency lights were regularly tested by the building owners. There were annual fire evacuation drills .We saw records confirming that these checks had been carried out. However, not all staff had attended fire training. There were no nominated fire wardens and the fire procedure was not written down for staff and patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with regarding emergency procedures knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location.

These included those for the treatment of cardiac arrest and bacterial infections. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The defibrillator and oxygen were accessible and records of regular checks were up to date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. However, only the

Inadequate

Are services safe?

practice manager held a copy of the plan at their home, it would therefore have been difficult to make arrangements in the event of an emergency if the practice manager was away from home.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who filled in CQC comment cards.

All the clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. However, these were not consistently applied. We found the monitoring of patients who were prescribed a medicine called Warfarin was inconsistent and presented risks. (Warfarin is the main anticoagulant used in the UK; an anticoagulant is a medicine that stops blood from clotting). For example, we saw that a prompt put on a patient's records by a clinician in February 2015, "see in two weeks' time" had not been acted upon. There was no evidence that at the time of the inspection that the patient had been seen by a clinician.

We found that some patients who were prescribed high risk medicines commonly known as disease-modifying anti-rheumatic drugs (DMARDs) had prescriptions issued without firstly checking their blood test results. DMARDs are medicines that are normally prescribed as soon as rheumatoid arthritis is diagnosed, in order to reduce damage to the joints. They can sometimes have serious side-effects affecting the blood, liver, or kidneys. As they are taken for a long time, patients need to have regular blood tests to see if the DMARDs are having any side-effects. We spoke with two GPs about DMARDs, one told us they did monitor patients' bloods and the other told us they didn't.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The outcomes of patients' care and treatment were not regularly monitored. We found the practice was not completing effective clinical audits. We asked to see examples of clinical audits that had been undertaken in the last year. Some audits of medicines had been carried out, but there was no evidence of any recent completed cycles. The practice did participate in some local audits and benchmarking but it was unclear what impact these had on practice protocols. For example, a medicines audit had highlighted that the practice had a high prescribing rate for a particular medicine. One of the GPs told us that an external company was commissioned to review this; they said the prescribing rate had reduced but did not know the detailed figures and there remained no practice policy on prescribing the medicine.

We saw evidence of an audit of minor surgery. This had taken place following a complaint about a missed referral to secondary care for further investigation following a minor surgery. This was a single-cycle audit; therefore there was no review of whether the planned improvements had been effective. One of the suggested improvements was that patients would be given an information sheet after a minor surgical procedure to request them to contact the practice 10-14 days later to confirm whether any test results had been received and any necessary follow-up referrals made. This meant that the responsibility lay with the patient to check that the correct procedures had been followed and there was a risk that patients may have remained unaware of an abnormal result.

Nationally reported data taken from the Quality and Outcomes Framework (QOF) for 2013/14 showed the practice had not achieved maximum points for the majority of the 20 clinical conditions covered (with an overall score of 71.4%, compared to 94.5% within the CCG and 93.7% nationally). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme rewards practices financially for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually). There were a number of indicators where the practice was performing well below the levels of other practices, both locally and nationally. This included the clinical indicators relating to epilepsy (59% below local and 63% below national averages) and asthma (44% below local and 43% below national averages). The practice had not achieved any of the points for the depression indicator. The practice manager told us the practice did not focus on targets and they felt that some of the data may have been incorrect.

Inadequate

Are services effective?

(for example, treatment is effective)

The local clinical commissioning group (CCG) and NHS England had written to the practice earlier in 2015. They had requested a formal action plan from the practice, to show how they were going to improve. The practice manager told us that this action plan had not yet been developed.

In addition to the low overall score for QOF, there were some unusual exception reporting rates. The practice manager told us if a patient did not attend appointments or respond to invites then they would be 'exempted', as per the QOF guidelines (QOF includes the concept of 'exception reporting' to ensure 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). For example, the percentage of patients on the Chronic Kidney Disease register who were being treated with a particular type of medicine had an exception rate of 25% (compared to the CCG average of 15%). However, the practice manager was unable to explain the reasons for the variations in the figures.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients who were at the end of their life and their families.

Effective staffing

We had previously inspected the practice in October 2013. During this inspection we identified a number of concerns; specifically that staff were not supported to an appropriate standard to carry out their roles effectively. This was because staff had not received the training they needed and were not supported by having regular appraisals.

We returned to the practice to carry out a further inspection in June 2014. During that inspection we found that the practice had still not completed all of the necessary actions.

During this inspection we found that the majority of staff had received appraisals. The nurses appraised each other, as the practice manager did not feel competent to do this. During the appraisals, training needs were identified and future career development plans were discussed. Staff told us they felt supported.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation (every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with NHS England).

We reviewed staff training records and saw that staff were up to date with attending some mandatory courses such as basic life support. However, training on fire safety and information governance had not been undertaken by all staff. There were no clear plans to suggest when this training would take place. Some role-specific training had been provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. The practice closed during an afternoon once a month for protected learning time (Time In, Time Out sessions).

Staff training records were incomplete. The practice manager told us that the nurses held their own records. This meant there was no overall record of training that took place within the practice. The practice had not provided staff with training in information governance or equality and diversity. Staff were not proactively supported to acquire new skills and share best practice.

Working with colleagues and other services

The practice worked with other health and social care providers, to co-ordinate care and meet people's needs.

We saw that various multi-disciplinary meetings were held. For example, regular palliative care meetings were held, which involved practice staff and the district and palliative care nurses. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw procedures were in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hour's provider and the ambulance service.

Information sharing

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

Inadequate

Are services effective?

(for example, treatment is effective)

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use.

Correspondence from other services such as blood results and letters from the local hospital, including discharge summaries, was received both electronically and by post. However, the arrangements for reading and taking action to address any issues arising from communications from other care providers were unclear. The administrative staff understood their roles and how the practice's systems worked but we saw differing approaches by GPs in relation to how they communicated any action required to the reception staff who dealt with the correspondence. The inconsistent approach meant there was a risk that changes to patient's records were not made correctly and there was no clear audit trail as to any changes made. The practice manager told us these arrangements were in place because the GPs were individuals who worked differently.

Consent to care and treatment

There was no clear guidance for staff on when to document consent. When we spoke with staff they were unaware whether there was a practice policy on consent. However, staff were all able to give examples of how they obtained verbal or implied consent. We saw that written consent had been obtained where necessary, for example, for minor surgery procedures.

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Although staff had not received specific training, they were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Decisions about or on behalf of patients who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. The GPs described the procedures they had followed where people lacked capacity to make an informed decision about their treatment.

Health promotion and prevention

The practice identified people who needed ongoing support. This included carers, those receiving end of life care and those at risk of developing a long-term condition. For example, there was a register of all patients with dementia. However, nationally reported QOF data (2013/14) showed that the practice had obtained 75.8% of the points available for providing recommended clinical care and treatment to dementia patients. The data indicated that only 50% of patients with dementia had received a range of specified tests, six months before or after being placed on the practice's register. This was 22.0 percentage points below the local CCG average and 23.6 points below the England average.

The QOF (2013/14) data showed that the practice had not supported patients to stop smoking. The data showed that the practice had only obtained 53.8% of the points available to them for providing support with smoking cessation. This was 40.4 percentage points below the local CCG average and 39.9 points below the England average. The practice had obtained 100% of the points available for providing cervical screening to women. This was 0.8 percentage points above the local CCG average and 2.5 above the England average.

New patients were offered a 'new patient check', with a nurse, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice offered a full range of immunisations for babies and children, as well as travel and flu vaccinations, in line with current national guidance. Vaccination rates for 12-month and 24-month old babies and five-year-old children were in line with the local CCG area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP survey (January 2015). The scores in relation to patients' last appointment with a doctor or nurse were above national averages. For example,

- 96% of patients said they had confidence and trust in their GP (compared to 93% nationally)
- 90% of patients said they had confidence and trust in their nurse (compared to 86% nationally)
- 85% of patients said the GP treated them with care and concern (82% nationally)
- 86% of patients said the nurse treated them with care and concern (compared to 78% nationally).

We spoke with 13 patients during our inspection. All except one was happy with the care they received. People told us they were treated with respect and were very positive about the staff. Comments left by patients on the 18 CQC comment cards we received also reflected this. Words used to describe the approach of staff included friendly, caring, and helpful.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in those rooms could not be overheard.

We saw that the reception staff treated people with respect and ensured that conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately.

Care planning and involvement in decisions about care and treatment

Patients were satisfied with the level of information they had been given. We reviewed the 18 completed CQC comment cards, patients felt they were involved in their care and treatment.

The results of the National GP Patient Survey from January 2015 showed that patients felt involved in their care and treatment. The scores for nurses were all well above the national average:

- 88% said the last GP they saw or spoke to was good at listening to them (national average 88%)
- 78% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%)
- 89% said the last nurse they saw or spoke to was good at listening to them (national average 79%)
- 86% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 67%).

We saw that access to interpreting services was available to patients, if they required it. Staff we spoke with said the practice did not have many patients whose first language was not English. They said when a patient requested an interpreter, a telephone service was available. There was also the facility to request translation of documents if it was necessary to provide written information for patients.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us that staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring and took time to help and support them.

We saw a variety of information on display throughout the practice. There were several noticeboards with a range of information regarding common health conditions and local support groups.

The practice routinely asked patients if they had caring responsibilities and had set up a carer's register to help them identify and make sure they were receiving the professional support they needed. A member of staff within the practice took the lead on caring for carers. Their role was to promote the awareness of patients with caring responsibilities and ensure that such patients were informed about the support available.

Support was provided to patients during times of bereavement. Clinical staff referred patients struggling with loss and bereavement to support groups who provided these types of services.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The majority of patients we spoke with and those who filled out CQC comment cards said they felt the practice was meeting their needs. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability, this was noted on their medical records. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from January 2015 reflected this; 88% (86% nationally) of patients thought the doctors and 88% (81% nationally) thought nurses gave them enough time.

The practice nursing team was responsible for delivering most of the care and treatment needed by patients who had a chronic disease. The practice offered an annual check of health and wellbeing for patients with long-term conditions, such as diabetes and heart disease, or this was offered if the nursing team judged necessary. Of the patients who participated in the National GP Patient Survey, 84% said the last nurse they saw was good at explaining tests and treatment (this was above the national average of 77%). However, the Quality and Outcomes Framework (QOF) data (2013/14) showed that not all patients had received a review. For instance, only 54% of patients on the asthma register had had an asthma review in the preceding 12 months (this was 22% below the local and national average).

QOF data showed that the practice had obtained 100% of the points available for providing recommended care and treatment to patients needing palliative care (this was 3.3 points above the national average). The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses and health visitors.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available for providing recommended maternity services. Nationally reported QOF data (2013/14) showed that antenatal care and screening were offered in line with current local guidelines. However, the data also showed that the practice had achieved none of QOF points in relation to child surveillance; this meant that child development checks were not offered at intervals consistent with national guidelines.

The QOF data showed that the practice had only achieved four out of the seven points available for the learning disability clinical domain. The practice manager told us they were aware of this and said that no-one in the practice "knew enough about it to provide a good service".

A patient participation group (PPG) had been established, to help the practice engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We spoke with two members of the PPG; they explained their role and how the group worked with the practice. The representatives told us the PPG had a good working relationship with the practice, They gave us examples of improvements that had been made following discussions between the PPG and the practice. This included additional chairs in the waiting room and the installation of a door bell at the front door.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, the computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. Where patients were identified as carers, we saw that information was provided to ensure they understood the

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

various avenues of support available to them if they needed it. The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference.

Staff at the practice recognised that patients had different needs and wherever possible were flexible to ensure that their needs were met. There was a system in place to alert staff to any patients who might be vulnerable or who had special needs, such as patients with poor mental health or a learning disability. Registers were kept, that identified which patients fell into these groups. The practice used this information to ensure patients received regular healthcare reviews and access to other relevant checks and tests. Some patients had been identified as always needing longer appointments and the system ensured that staff were alerted to this need.

The doors providing access to the surgery were not automated, but a doorbell had recently been installed so patients could summon help if necessary. We saw the consulting rooms were large with easy access for all patients. There were also toilets that were accessible to disabled patients and baby changing facilities. A hearing loop system was in place for patients who experienced difficulties with their hearing.

Only a small minority of patients did not speak English as their first language. There were arrangements in place to access telephone interpretation services for urgent appointments or book an interpreter to accompany patients where appointments were booked in advance.

The practice had a training matrix which showed that equality and diversity training was scheduled to be delivered annually. However, at the time of the inspection none of the staff had undertaken any such training.

Access to the service

The practice was open between 7:30am and 6pm every weekday, except Thursday when opening hours were 8pm until 6pm.

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face-to-face and telephone consultations were available to suit individual needs and preferences. Home visits were also made available every day.

Reception staff had been trained to take note of any urgent problems and notify the doctor, for example, an unwell child or parental concern. This was confirmed when we observed reception staff taking calls from patients. These patients were offered appointments on the same day.

The most recent National GP Patient Survey (January 2015) showed 89% of respondents were happy with the opening hours (compared to 76% nationally), 72% (compared to 73% nationally) of respondents were able to get an appointment or speak to someone when necessary. The practice scored very highly on the ease of getting through on the telephone to make an appointment (91% of patients said this was easy or very easy compared to the national average of 71%).

Patients were able to book appointments up to eight weeks in advance, urgent appointments were available each day. The next available routine appointment was eight days after our inspection. The practice manager said that six routine appointments were released at 8:30am (to get an appointment the same morning) and 1:30pm (for an afternoon appointment) each day.

The GP Patient Survey data showed that 33% of patients waited more than 15 minutes for their appointment, compared to a local average of 21% and a national average of 27%. During our inspection we saw that some patients waited a long time for their appointment. For example, one person had an appointment booked for 9:50am; they were called in at 10:40am. Another patient had an appointment booked for 10:30am and they were called at 10:55am. A third had an appointment at 10:40am and they were called at 11:00am. The GP Patient survey showed that 33% of patients said they waited more than 15 minutes for their appointment, compared to a national average of 27% and a local average of 21%). During this time we saw several patients approach the reception staff to ask for an update on when they would be called for. Patients were not kept up to date with information about any likely delays. We asked the practice manager what arrangements were in place to monitor waiting times. They told us they carried out some reviews and if any trends were identified then this was discussed with the relevant doctor.

There were arrangements in place to ensure that patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed,

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The local out-of-hours provider was Primecare.

We found that the practice had a clear, easy to navigate website which contained detailed information to support patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice.

None of the 13 patients we spoke with during the inspection said they had felt the need to complain or raise concerns with the practice. None of the 18 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with knew how to address complaints. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

The arrangements for recording complaints were unclear. There were no clear records held in relation to complaints. In advance of the inspection we asked the practice to provide us with a summary of any complaints received in the last 12 months. We received a schedule which showed the practice had received five formal complaints. During the inspection we spoke with staff who told us they did not always document any informal or verbal complaints. We asked the practice manager about this and they told us they were all recorded. However, the schedule that we saw only contained details of the written complaints.

We looked at some of the complaints the practice had received. We saw these had all been thoroughly investigated. The complainant had been communicated with throughout the process and the practice apologised when they did not do as well as they should have done. We saw the clinicians involved had reviewed what had happened and what could be learned to prevent a reoccurrence. However, agreed changes were not always implemented. For example, following one complaint it had been agreed that minor surgical operations would be monitored on a monthly basis. But we saw records that showed that the procedures had been reviewed on a quarterly basis, rather than monthly.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision. The practice manager confirmed this and it was evident in the discussions we had with other staff throughout the inspection. The practice manager told us they felt the purpose of the practice was to "provide good care holistically and be good family doctors". Other staff told us they "did their best for people". There was no documented practice strategy for future development.

The practice did not have a business plan in place that set out the priorities for the future. We asked the practice manager if the practice had a documented strategy or a business plan with actions for future improvement. They confirmed they did not.

Governance arrangements

The delivery of high quality care was not assured by the governance arrangements in place. There was insufficient information or documented evidence made available during the inspection to demonstrate this. The practice did not have systems in place to regularly monitor and assess the quality of services provided.

We asked the practice manager to show us the policies and procedures that enabled the practice to identify, assess and manage risks relating to the health, welfare and safety of patients. They told us they felt there was too much emphasis on paperwork. Practice policies were updated on an ad-hoc basis; there was no timetable in place to check policies to ensure they remained relevant. When policies were updated, the practice manager sent an email to staff or verbally advised them to read them. There were no follow up arrangements in place to check whether staff had read and understood the policies. Some policies that we saw related to different organisations, and others had not been personalised to reflect the practice's requirements.

We spoke with staff and it was evident that lack of formal guidelines meant there were inconsistencies in their practice. For example, we saw differing approaches by GPs on receipt of letters from hospital following patient discharge, in terms of how they communicated any action required to the reception staff who dealt with the correspondence. We raised this with the practice manager and they told us that the GPs were individuals who worked in different ways. The practice also employed locums, and the lack of clear policies and procedures meant there were no clear guidelines for such staff to follow.

There was little monitoring of performance. We asked the practice manager what arrangements were in place to measure the performance of the practice. They told us they "base it on what patients say and are not target pushers". The results from the Quality and Outcomes Framework (QOF) in 2013/2014 showed that the practice had achieved an overall QOF score of 71.4% of the maximum points available; this achievement was well below both the local Clinical Commissioning Group (CCG) and the national averages (94.5% and 93.5% respectively). This showed the practice had not delivered care and treatment in line with expected national standards.

The QOF data also showed a number of areas where performance differed from the national average (for example, high exception rates within some individual clinical indicators). We asked the practice manager to explain the variations. They were unable to demonstrate an understanding of the results.

Data was not submitted to external organisations as required. Prior to our inspection, NHS England had raised concerns about the practice's performance. NHS England had identified some areas of poor performance and had written to the practice in January 2015 to ask them to provide an action plan to show how they were going to improve. The practice manager told us this had not yet been done as they were waiting for someone from NHS England to provide some support to the practice to complete this. The practice manager also told us they "didn't believe some of the data" that NHS England had used to compare performance. However, they were unable to provide alternative data to demonstrate where these differences had occurred.

Leadership, openness and transparency

The practice had a management team but there was a lack of effective leadership. There were no clear priorities or a development strategy for the leadership of the practice. The practice manager told us discussions were ongoing about the future partnership arrangements but these had not been formalised.

Staff told us they attended practice meetings monthly. We looked at the minutes from some of the meetings held. The

Are services well-led?

Inadequate

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

minutes did not refer to discussions about the quality of the service provided or any shared learning. For example, there was no evidence of shared learning across the practice team from complaints received.

The practice had a structure which had named members of staff for some lead roles. For example, one of the GP partners was the lead on safeguarding and the practice nurses led on the management and monitoring of some chronic diseases.

Staff told us that they felt valued, well supported and knew who to go to in the practice with any concerns. However, some staff said they felt they could be better informed of what was happening in the practice, and they did not get much feedback from the GP partner's meetings. Most staff told us they had received training, however, there were no robust systems in place in terms of monitoring training and ensuring it provided staff with all of the skills needed to carry out their role.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had made arrangements to seek and act on feedback from patients and staff. There was a section on the website where patients could submit comments or suggestions and suggestion boxes in the waiting room.

There was a patient participation group (PPG) open to all patients. The PPG included representatives from some of the key population groups. Regular meetings were held; the practice manager always attended to support the group. We spoke with two members of the PPG and they felt the practice generally supported them with their work and took on board any concerns they raised.

NHS England guidance stated that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT). The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices.

The practice had recently introduced the FFT. However, on the day of our inspection there were no questionnaires available. The practice manager told us they had been temporarily removed to make room for the CQC's patient comments box. Guidance from NHS England states that "patients should be made aware that the opportunity is available to those that want to provide feedback through the FFT at any time".

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information.

Management lead through learning and improvement

The practice had not completed regular formal reviews of significant events, complaints or other incidents or shared these with staff through meetings. There was little innovation or service development.

Staff from the practice attended the monthly CCG protected learning time (Time In, Time Out) initiative. This provided the team with dedicated time for learning and development. There was some evidence of learning. However, some compulsory training had not been carried out, despite receiving compliance actions to this effect following two previous CQC inspections.

GPs met with colleagues at CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice. The practice manager met with other practice managers in the Sunderland area.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The practice did not effectively and safely manage medicines. The practice did not have effective infection prevention and control arrangements in place. Regulation 12 (2) (g) and (h).

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 How the regulation was not being met: Staff did not always receive appropriate training to enable them to carry out their duties. Regulation 18 (2) (a).

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not established and operated effectively in order to assess, monitor and improve the quality of service provided in carrying out the regulated activities. The evaluation of information to improve practice had not been carried out effectively. Regulation 17 (1) and (2) (a) (b) and (f).

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 How the regulation was not being met: Some information specified in Schedule 3 of the Health & Social Care Act 2008 in respect of people employed for the purposes of carrying on a regulated activity was not available. The practice could not demonstrate that regular checks were carried out to ensure that the health care professionals employed continued to meet the professional standards which are a condition of their ability to practise or a requirement of their role. Regulation 19 (3) (a) and (4) (a) and (b).