Hendon Way 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?	Requires improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hendon Way Surgery on 11 October 2017. Overall the practice is rated as inadequate.

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

- Patient outcomes were hard to identify. Although there were audits carried out, there was no evidence of completed two cycle audits or other quality improvement to improve patient outcomes.
- Data from the Quality and Outcomes Framework showed patient outcomes were above the national average, however exception reporting rates were significantly higher than both CCG and national averages.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the system for managing high risk medicines was inconsistent and we found evidence of risks to patient safety.
- The practice had a leadership structure, however there was a lack of clarity around key roles within the practice
- There were systematic weaknesses in governance arrangements. For example, in the arrangements for managing uncollected prescriptions, patient safety alerts, significant events and the recording of consent.
- There were ineffective systems in place for managing staff training and limited evidence of a formal induction programme.
- Patient satisfaction was significantly below local and national averages for access to the service and clinical consultations with GPs and nurses.

The areas where the provider must make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Summary of findings

- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training and professional development necessary to enable them to carry out the duties.

The areas where the provider should make improvement are:

- Improve governance processes for sharing learning identified through significant events, safeguarding adults, and cascading of nationally recognised guidance.
- Improve the audit system in relation to the monitoring of prescription pads in accordance with national NHS guidelines.
- Review clinical exceptions for all long term conditions to ensure they meet the clinical criteria for exception reporting and identify ways to reduce exception reporting.
- Review the processes for improving the uptake of child immunisations, cervical screening, bowel cancer screening and breast cancer screening.
- Improve patient satisfaction around access to the service and clinical consultations with GPs and nurses.
- Improve how patients with caring responsibilities are identified and recorded on the patient record system to ensure information, advice and support is made available to them.

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 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.

- There was a system in place for reporting and recording significant events and staff understood their responsibilities in relation to reporting significant events. However, when things went wrong lessons learned were not communicated widely enough to support improvement.
- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. This included the system for managing high risk medicines which was inadequate and uncollected prescriptions.
- We saw evidence of effective protocols in place for child safeguarding. However, we were not assured that adult safeguarding protocols were effective.
- Blank prescription forms and pads were securely stored however there were no systems to monitor their use
- Patient Group Directions (PGD) had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. PGDs allow registered health professionals to administer specified medicines to a pre-defined group of patients.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Inadequate

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

- Data showed patient outcomes were comparable to local and national averages. However the exception reporting rate for patients with long-term conditions was significantly higher than both CCG and national averages.
- Uptake for cervical screening programme, child immunisations, bowel cancer screening and breast cancer screening was significantly below the national average.
- There was no evidence that audit was driving improvement in patient outcomes.
- There was limited evidence that the practice was comparing its performance to others; either locally or nationally.

Summary of findings

- There was no evidence of a formal induction programme outlining the required competencies for staff to effectively fulfil their individual roles.
- The practice could not always demonstrate role-specific training, for example, for medical staff performing cervical screening.
- Although staff had been appraised we were not assured that training needs were identified as a result of appraisal.
- Basic care and treatment requirements were not met. For example, the practice were unable to demonstrate the recording of patient consent or evidence of structured care plans.

Are services caring?

Requires improvement 

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

- Data from the national GP patient survey showed patients rated the practice lower than others for most aspects of care. For example, 73% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- Less than one percent of the patients registered at the practice had been identified as carers.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Inadequate 

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

- Feedback from patients was significantly below the local and national average and reported that access to a named GP and continuity of care was not always available quickly.
- We were not assured that the practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available and evidence from 10 examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Inadequate

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

- The practice had a number of policies and procedures to govern activity however we identified that policies were not being following.
- The practice told us they prioritised safe and high quality care however we found evidence of inconsistent care resulting in significant patient safety concerns.
- There were systematic weaknesses in governance processes.
- The practice did not have a clear vision and strategy.
- There was a leadership structure in place but there was a lack of clarity around key roles within the practice.
- The practice had sought feedback from the PPG however there was limited evidence that the practice acted on staff or patient feedback.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

- Care and treatment of older patients, including those receiving end of life care, did not always reflect current evidence-based practice, and some older people did not have care plans.
- The practice did not follow up on older patients discharged from hospital or ensure that their care plans were updated to reflect any extra needs.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- The practice provided an in-house phlebotomy service.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Inadequate

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

- Exception reporting rates for diabetes were significantly higher than local and national averages. For example, the exception reporting rate for patients with diabetes, on the register, in which the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months was 30%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.
- The practice told us GP staff had lead roles in long-term disease management, however the practice website indicated that asthma clinics were nurse led.
- Performance for diabetes related indicators was higher than the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood

Summary of findings

pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 83% compared to the CCG average of 77% and the national average of 79%. However, exception reporting was 15.3% (CCG average and national average 9%).

- The practice told us they followed up on patients with long-term conditions discharged from hospital when it was appropriate.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review.

Families, children and young people

Inadequate

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

- Immunisation uptake rates for the standard childhood immunisations were below the national average.
- Appointments were available outside of school hours. However, patient feedback indicated that it was difficult to book appointments.
- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk.
- The premises were suitable for children and babies.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

Inadequate

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

- Although the practice offered extended opening hours for appointments from Monday to Friday, patient feedback indicated that booking appointments was difficult.
- The practice offered online services and clinical telephone consultations.
- There was a low uptake for both health checks and health screening.

Summary of findings

- The age profile of patients at the practice was mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group.
- Health promotion advice was offered.

People whose circumstances may make them vulnerable

Inadequate

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

- The practice did not hold a register of vulnerable adults.
- The practice had identified less than one percent of the patient population as carers.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

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

- The practice system for monitoring uncollected prescriptions for patients receiving medicines for mental health needs lacked clinical oversight.
- Exception reporting for mental health indicators was higher than local and national averages. For example, from a total of six indicators for mental health three of these had exception reporting rates of 10% and above, three were above 20%.

Summary of findings

- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2017. The results showed the practice was performing significantly below with local and national averages. A total of 373 survey forms were distributed and 127 were returned. This represented 1.4% of the practice's patient list.

- 68% of patients described the overall experience of this GP practice as good compared with the Clinical Commissioning Group (CCG) average of 82% and the national average of 85%.
- 39% of patients described their experience of making an appointment as good compared with the CCG average of 68% and the national average of 73%.
- 57% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 75% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were all positive about the standard of care received; seven of the cards noted it was difficult to book appointments and access the surgery by phone.

We spoke with four patients during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable and caring. Three of the patients we spoke with told us it was difficult to contact the practice by phone and availability of appointments was limited.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training and professional development necessary to enable them to carry out the duties.

Action the service SHOULD take to improve

- Improve governance processes for sharing learning identified through significant events, safeguarding adults, and cascading of nationally recognised guidance.
- Improve the audit system in relation to the monitoring of prescription pads in accordance with national NHS guidelines.
- Review clinical exceptions for all long term conditions to ensure they meet the clinical criteria for exception reporting and identify ways to reduce exception reporting.
- Review the processes for improving the uptake of child immunisations, cervical screening, bowel cancer screening and breast cancer screening.
- Improve patient satisfaction around access to the service and clinical consultations with GPs and nurses.
- Improve how patients with caring responsibilities are identified and recorded on the patient record system to ensure information, advice and support is made available to them.

Hendon Way Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Hendon Way Surgery

Hendon Way Surgery is located in the London Borough of Barnet within the NHS Barnet Clinical Commissioning Group. The practice holds a General Medical Services contract (an agreement between NHS England and general practices for delivering primary care services to local communities). The practice provides a full range of enhanced services including childhood immunisation and vaccination, meningitis immunisation, extended hours access, dementia support, influenza and pneumococcal immunisations, learning disabilities support, rotavirus and shingles immunisation and unplanned admissions avoidance.

The practice is registered with the Care Quality Commission to carry on the regulated activities of family planning, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures.

The practice had a patient list size of 8,773 at the time of our inspection. The practice had a higher proportion of people with a long standing health conditions than local average (53% compared to the CCG average of 49% and the national average of 55%). The practice serves a diverse community. According to the nationality data submitted by the practice the most prevalent population groups included 21% Non-British White, 16% British, 7% Indian and 6% African. The remainder of the patient cohort was a mixture of 29 different nationalities.

At 81 years, male life expectancy was above the CCG average of 78 years and the England average of 79 years. At 85 years, female life expectancy was above with the CCG average of 82 years and the England average of 83 years.

The practice has fewer patients aged 60 years of age and older compared to an average GP practice in England. The percentage of patients between the ages of 20 and 44 is higher than the average GP practice in England. The surgery is based in an area with a deprivation score of six out of ten (one being the most deprived). Older people registered with the practice have a higher level of income deprivation compared to the local and national averages. Patients at this practice have a similar rate of unemployment when compared to the national average.

The clinical team at the practice included four GP Partners (two females, two males) and two female practice nurses. The non-clinical team at the practice included one practice manager, an interim practice manager covering maternity leave and seven administrative staff. There were 29 GP sessions available per week.

The practice is open Monday to Friday from 8.00am to 6.30pm. Phones lines are closed daily between 1.00pm and 2.00pm and were covered by the practice's out of hour's provider during this time. The surgery closes every Wednesday between 12.30pm and 2.00pm for training purposes.

Extended hours access is available Monday to Friday from 6.30pm to 7.10pm for pre-booked appointments.

Urgent appointments are available each day and GPs also provide telephone consultations for patients. An out of

hour's service is provided for patients when the practice is closed. Information about the out of hour's service is provided to patients on the practice website and the practice phone system.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 11 October 2017. During our visit we:

- Spoke with a range of clinical and non-clinical staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- From the sample of eight documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. However, when we reviewed the significant event analysis we found that learning wasn't always shared. For example, we reviewed a significant event regarding a two week referral that was delayed. We saw evidence that the practice took action to resolve the issue. There was no evidence however that the learning was shared with the hospital where the referral had been misplaced.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to minimise risks to patient safety. Evidence reviewed on the day of inspection indicated that systems in place for safeguarding adults required review.

- There were arrangements in place for safeguarding children. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of six documented examples of child safeguarding we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. We reviewed adult safeguarding processes and the practice identified one adult as being vulnerable. However, when we checked the clinical system we found there was no safeguarding alert for the vulnerable adult patient.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. Administration staff were trained to child safeguarding level 1. Following the inspection the practice provided evidence that GPs were trained to child safeguarding level 3 and nurses were trained child safeguarding level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and evidence that staff had received up to date training was provided following the inspection
- Annual IPC audits were undertaken and an action plan was in place to address any improvements identified as a result. We reviewed the most recent audit from 2017 and found that several of the points identified on the action plan had not been addressed such as the installation of mixer water taps and replacement of carpet in clinical consultation rooms. The practice told us that these issues had not been addressed as the practice would be moving to new premises within the next couple of months. The practice were unable to provide evidence of a lease for the new premises at the time of our inspection, however they did provide evidence that plans for the new lease were underway.

Inadequate

Are services safe?

There were arrangements in place for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal). However we found significant areas of concern in relation to inconsistent management of medicines.

- We asked for the practice protocol for the management of high risk medicines. The protocol shared with us did not identify what a high risk medicine was, did not include NICE guidance or any other nationally recognised clinical guidance or describe the frequency and type of monitoring required in order to ensure safe management of high risk medicines. We reviewed records for patients on warfarin, methotrexate, azathioprine and lithium. We found that the process for managing these high risk medicines was not consistent across the practice. We found examples for each of these high risk medicines where patients had been issued with prescriptions without the appropriate monitoring information being available to the prescriber. For example:

1. We reviewed 8 records for patients on warfarin and identified 6 records were not in line with national prescribing guidance and contained no evidence of blood monitoring.
2. We reviewed 8 records for patients on azathioprine and identified 4 records were not in line with national prescribing guidance and contained evidence that the most recent blood monitoring had taken place seven months prior to the issuing of a prescription.
3. We reviewed 10 records for patients on methotrexate and identified 5 records were not in line with national prescribing guidance and that prescriptions were issued without evidence of blood results being monitored within three months prior to issuing.
4. We reviewed 4 records for patients on lithium and identified all four were not in line with national prescribing guidance. For example, one prescription had been issued with no evidence of blood results and three of the prescriptions had been issued with the most recent blood results taking place seven months prior to issuing.

- Following the inspection we wrote to the practice in relation to our concerns about the safety of patients being issued high risk medicines. The practice responded and provided us evidence that a clinical review of all patients on high risk medicines had been conducted. The practice produced a policy for the management of high risk medicines which contained national clinical guidance. A GP partner was nominated as the lead for the management of high risk medicines and would be responsible for overseeing monthly reviews to ensure protocols for the safe management of high risk medicines were being followed. However, this action was a direct result of the inspection and not an improvement identified by the practices own governance systems.
- Blank prescription forms and pads were securely stored however there were no systems to monitor their use. We asked the practice for evidence that this issue was being addressed and they were unable to provide evidence of a governance process in place to effectively monitor prescription forms and pads.
- We found there was a lack of clarity and clinical oversight with regard to the management of uncollected prescriptions. We reviewed the practice policy for uncollected prescriptions; the policy stated uncollected prescriptions would be checked every three months by a receptionist. The policy did not state that a clinician must review the uncollected prescriptions and did not indicate what the process was for dealing with uncollected prescriptions. We spoke to three members of staff on the day of inspection we were told by one member of staff that uncollected prescriptions were checked once a month and a note was made on the patient record to state that the prescription had not been collected, the prescription would then be disposed of in confidential waste. The other two members of staff told us that uncollected prescriptions were checked every month by reception staff and shredded or disposed of in confidential waste. We looked at the uncollected prescriptions on the day of inspection and found that one was six weeks old and one was eight weeks old.
- During the inspection the policy was updated to state that uncollected prescriptions would be checked once a month, reviewed by a clinician and a note would be documented on the patient record or the patient would

be phoned if directed by the clinician. Despite the policy change, the practice was unable to provide evidence of clinical oversight in the management of uncollected prescriptions.

- The sessional practice nurse had recently qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. Patient Group Directions had been adopted by the practice to allow the full time practice nurse to administer medicines in line with legislation. PGDs allow some registered health professionals to administer specified medicines to a pre-defined group of patients.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Evidence that staff receive basic life support training was provided following the inspection and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians told us they were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice gave us two first cycle audits based on NICE guidance to evidence clinicians were up to date with current guidance.

However, on the day of inspection we found that the practice did not have a formal system in place to keep all clinical staff up to date. They told us that it was up to each individual member of staff to be aware of new guidance and use this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results at the time of the inspection were from 2015/16 and showed that the practice had achieved 93.4% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%.

Although performance for indicators was comparable or above local and national averages, there were many areas with significantly high exception reporting. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Due to the number of concerns identified at the inspection we were unable to ask the practice for an explanation about the high rates of exception reporting.

According to the 2015/16 published data the practice was not an outlier for any QOF (or other national) clinical targets. The most recent data for 2016/17 had not been published at the time of our inspection. On the day of inspection we asked the practice to provide us with the unvalidated data from 2016/17 but they were unable to provide this. The 2016/17 data was published nationally shortly after the inspection. Although the 2016/17 data showed an improvement in overall achievement, exception reporting rates for 2016/17 were significantly above local and national averages for several indicators and had largely increased from the reported rates in 2015/16.

The most recently published data from 2016/17 showed that:

- Performance for diabetes related indicators was higher than the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 83% compared to the CCG average of 77% and the national average of 79%. Exception reporting was 15.3% (CCG average and national average 9%); this was a significant increase from the exception reporting rate of 1.2% in 2015/16.
- Performance for mental health related indicators was higher than the CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the preceding 12 months was 96% compare to the CCG average of 91% and the national average of 90%. Exception reporting was 12.9% (CCG average 8% and national average 12.5%); this was a significant increase from the exception reporting rate of 5.5% in 2015/16.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators was higher than the CCG and national averages. For example, the percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 96% compared to the CCG average of 93% and the national average of 91%. Exception reporting was 19% (CCG average 8.3% and national average 12%); this was a significant increase from the exception reporting rate of 6.6% in 2015/16.
- Performance for hypertension related indicators was with the CCG average and below the national averages. For example, the percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg

or less was 80% compared to the CCG average of 79% and the national average of 77%. Exception reporting was 2.5%; this was an increase from the exception reporting rate of 0.7% in 2015/16.

- Performance for asthma related indicators was higher than the CCG and national averages. For example, the percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 Royal College of Physicians questions was 79% compared to the CCG average of 78% and the national average of 77%. Exception reporting was 2.6%; this was comparable to the exception reporting rate of 2.3% in 2015/16.
- Performance for atrial fibrillation related indicators was comparable to the CCG and national averages. For example, for those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy was 86% compared with the CCG average of 85% and the national average of 88%. Exception reporting was 12% (CCG average 8.3% and national average 12%); this was slightly lower than the exception reporting rate of 12.8% in 2015/16.

Other areas where there were significantly high rates of exception reporting included:

Diabetes

From a total of 10 indicators for diabetes six of these had exception reporting rates above 20% and the remaining four had exception reporting rates above 10%. For example:

- The exception reporting rate for patients with diabetes, on the register, in which the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months was 30% compared to the CCG average of 11.5% and the national average of 14%.The exception reporting rate for patients with diabetes, on the register, in which the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months was 20% compared to the CCG average of 7.4% and the national average of 9.2%.

COPD

From a total of four indicators for COPD two of these had exception reporting rates above 10%, two were above 20% and one was below 10%. For example:

- The exception reporting rate for patients with COPD with a record of FEV1 in the preceding 12 months was 24% compared to the CCG average of 10.8% and the national average of 16.5%.
- The exception reporting rate for patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register was 16% compared to the CCG average of 8% and the national average of 9%.

Dementia

- The exception reporting rate for patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 12 months before or 6 months after entering on to the register was 40% compared to the CCG average of 26% and the national average of 23%.

Heart failure

- The exception reporting rate for patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register was 16% compared to the CCG and national average of 4%.

Mental Health

From a total of six indicators for mental health three of these had exception reporting rates of 10% and above, three were above 20%. For example:

- The exception reporting rate for patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months was 20% compared to the CCG average of 4% and the national average of 3%.

Osteoporosis

Both indicators for osteoporosis had exception reporting rates above 20%. For example:

- The exception reporting rate for patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014

and a diagnosis of osteoporosis, who are currently treated with an appropriate bone-sparing agent was 50% compared to the CCG average of 20% and the national average of 19%.

Peripheral arterial disease

- The exception reporting rate for patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken was 35% compared to the CCG average of 10% and the national average of 6.8%.

Stroke and transient ischaemic attack

- The exception reporting rate for patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken was 17% compared to the CCG average of 8% and the national average of 5.6%.

There was limited evidence of quality improvement including clinical audit:

- There had been seven clinical audits commenced in the last two years, however none of these were completed audits where the improvements made were implemented and monitored.
- Following the inspection the practice submitted a second cycle for the audit of inadequate smears completed on 3 October 2016. The audit from October 2016 showed an inadequate smear rate of 5% for the period 1 September 2015 to 31 September 2016; the frequency of the audit was listed as 'at least every two years'. The first audit cycle identified a total of 395 smears were performed during this period between three sample takers at the practice with an adequate rate of 5% overall. The audit did not include the number of smears performed per sample taker and therefore did not effectively measure whether additional training was required to improve the service. The second cycle of the audit completed on 13 October 2017 identified an inadequate smear rate of 1% for a total of 487 smears carried out between 1 October 2016 and 31 September 2017. The second cycle audit did show an improvement in the overall inadequate rate, however there was no information indicating how that improvement was achieved.

Effective staffing

The practice had difficulty providing evidence to show that staff had the skills and knowledge to deliver effective care and treatment. We asked for additional evidence of training following the inspection, most of the evidence we asked for was received. However, the additional evidence did highlight that the system for managing the training needs for staff was ineffective. For example:

- The practice told us there was an induction programme for all newly appointed staff however they were unable to provide us with evidence of a formal induction programme. The practice provided a new recruit welcome/induction checklist as evidence of the induction programme. However, the checklist did not include competencies required by new members of staff in order to fulfil their role.
- We reviewed staff files for two members of staff that were employed within the last 12 months. There was no formal induction information in either file to show that these new members of staff had been assessed as competent in their new roles or to indicate what competencies were relevant to their roles. We spoke to both of these members of staff on the day of inspection and we were told that they were given on the job supervised training; however they had not had any formal reviews to assess the competencies required for their roles. They also told us that they did not have one to one meetings with their line manager during their probationary periods to review their progress against the supervised training for their roles.
- The practice were unable to demonstrate how they ensured role-specific training and updating for relevant staff. For example, on the day of inspection we asked the practice how they decided what training is mandatory for staff and how mandatory training was monitored by the practice. We were told that the practice deemed training mandatory if it was listed as mandatory by CQC. CQC does not have a list of mandatory training for members of the GP practice team. This is because exact training requirements will depend on the role and specific responsibilities of practices and the needs of the people using the service.The practice were unable to provide evidence that training requirements were assessed based on individual responsibilities of staff.
- We were told that training was monitored by reviewing individual staff files to identify which training had not been completed. However, we found inconsistencies in

training completed by staff when we reviewed four staff files. For example, of the four files we reviewed, two members of clinical staff did not have evidence of completed infection and prevention control training (IPC) whereas two members of non-clinical did have evidence of completed IPC training. Following the inspection the practice submitted evidence of completed IPC training for one of the clinical members of staff whose file we reviewed at the inspection. However, the practice were unable to provide us with assurance that there was an effective system in place for ensuring staff were appropriately trained to perform their roles. This was evidenced by the fact we were unable to identify what training staff had completed by reviewing their files on the day of inspection.

- The practice told us that the learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months; however we had concerns around the learning needs of staff being identified. For example:

- The practice sent us information prior to the inspection stating that a clinical member of staff had completed mental capacity act (MCA) training. We spoke with a clinical member of staff who demonstrated knowledge and understanding of the MCA; however the practice were unable to provide evidence that MCA training had been completed. During interview it was identified that this member of staff was not aware of the Gillick competence. The Gillick competence is a method used by clinicians to determine whether children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment.

- The member of clinical staff was a sample taker at the practice; we had concerns around how their competency was assessed by the practice for this duty. The practice were unable to provide satisfactory evidence of cytology training and wewere not assured that the practice had effective systems in place to assess the competency of staff hired to perform this clinical role..

- The practice told us that all staff completed training for safeguarding, fire safety awareness, basic life support, infection and prevention control and information governance. Staff had access to and made use of e-learning training modules and in-house training. On the day of the inspection we reviewed four staff files. The files did not contain evidence of basic life support training for one member of staff, fire safety training for one member of staff, infection control training for two members of staff, mental capacity act training for all four members of staff and information governance training for three members of staff. The list of completed staff training submitted by the practice prior to the inspection did not match the findings on the day of inspection. For example, we found that the list of staff training included training that the practice could not provide evidence of completion for such as mental capacity act training. Additionally, we found that staff had completed training that was not recorded and that dates recorded for completed training on the list did not always match the dates on the training certificates. This was the only list of staff training the practice provided and we were told it was created specifically for the inspection. We were not provided with assurance that the practice had an adequate system in place to accurately record and monitor staff training.

- Staff administering vaccines had received specific training which had included an assessment of competence.Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. With regards to care plans, the practice told us there were multi-disciplinary team care plans for palliative patients but could not evidence this as they said the care plans were at the patient's house.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice told us that consultations and care planning take place following patients being discharged from hospital if appropriate.
- The practice told us that they do not complete audits of patients who had passed away.

We did find examples evidence in relation to multidisciplinary working. For example:

- From the sample of three documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Meetings took place with other health care professionals on a monthly basis patients with complex needs were reviewed for continuity of care.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff told us they sought patients' verbal consent to care and treatment in line with legislation and guidance. The practice were unable to provide evidence that patient consent was documented.

- Not all staff we spoke to on the day of inspection understood the relevant consent and decision-making requirements of legislation and guidance and were unable to provide us with examples of documented consent. For example, we asked the practice nurse to provide an example of recorded consent; we were given two examples of parental consent for child immunisations. We were told that the parents had consented and that the immunisations were given. However, when we reviewed the patient's records we found that it was documented in both records that the parents did not consent to the treatment. This was the only evidence the practice provided around documenting consent on the day of inspection.
- GPs at the practice demonstrated an understanding of capacity assessments for the care and treatment for children and young people; however the practice were unable to provide evidence that consent was documented for clinical procedures.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet andsmoking cessation

The practice's uptake for the cervical screening programme 2015/16 was 74%, which was below the CCG average of 77% and the national average of 81%. The practice provided us with unvalidated data for 2016/17 showing that the uptake for cervical screening was 72%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the CCG/national averages. For example, in 2015/16 childhood immunisation rates for the vaccinations given were lower when compared to the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. Data for 2015/16 showed that the practice did not achieve the target in all four areas. These measures can be aggregated and scored out of 10, the practice scoring 7.7 compared to the national average of 9.1.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice told us they encouraged patients to attend national screening programmes for bowel and breast cancer. Data for 2015/16 showed that the practice was below the local and national average for the uptake of bowel cancer screening and breast cancer screening. For example:

- female patients between the ages of 50-70 screened for breast cancer in last 3 years was 58% compared to the CCG average of 67% and the national average of 72%.
- Patients between the ages of 60-69 screened for bowel cancer in last 2.5 years was 43% compared to the CCG average of 50% and the national average of 58%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- 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.
- Patients could be treated by a clinician of the same sex.

We received 23 patient Care Quality Commission comment cards, 16 cards we received were positive about the service experienced. Seven patient comment cards contained positive comments about the treatment received from GPs and included negative comments around access to the service and the attitude of reception staff. The practice told us that the comments about reception staff attitude were related to a member of staff no longer employed by the practice.

We spoke with four patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed there were areas of patient satisfaction that were comparable to local and national averages, however the practice was mostly below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients 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%.
- 73% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 86%.
- 85% of patients said the nurse was good at listening to them compared with the CCG average of 88% and the national average of 91%.
- 80% of patients said the nurse gave them enough time compared with the CCG average of 90% and the national average of 92%.
- 96% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 85% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% national average of 91%.
- 62% of patients said they found the receptionists at the practice helpful compared with the CCG average of 84% and the national average of 87%.

The practice told us that they reviewed patient satisfaction scores annually with the patient participation group (PPG). We were told that a review did not take place this year due to the practice manager maternity leave which began in September 2017.

We were not provided with evidence to show that patient satisfaction around clinical consultations with GPs and nurses was identified as an area for improvement by the practice. The practice told us they asked the PPG to identify areas for improvement based on patient satisfaction at the PPG meeting in January 2017. We were told that the PPG identified the following areas for improvement:

- Improved telephone access for patients
- Improvements to the emergency appointment system
- Improve satisfaction for patients who are able to book an appointment with their preferred GP

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us

Are services caring?

they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Children and young people were treated in an age-appropriate way and recognised as individuals. For example, same day appointments are offered to children age 11 and under.

Results from the national GP patient survey showed patients satisfaction for their involvement in treatment and care was below the local and national averages. For example:

- 76% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 70% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 84% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 90%.
- 74% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% national average of 85%.

We were not provided with evidence to show that patient satisfaction around their involvement in treatment and care was identified as an area for improvement by the practice.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them (having a number of bi-lingual staff meant that the practice could provide members of staff that were fluent in a total of seven different languages in addition to English).
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 73 patients as carers (less than one percent of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We were not assured that the practice understood its population profile and had used this understanding to meet the needs of its population:

- Telephone lines were closed daily between 1.00pm and 2.00pm and were covered by the practice's out of hours provider during this time.
- The practice offered pre-booked extended hours appointments Monday through Friday from 6.30pm to 7.10pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- The practice provide an in-house cryotherapy service and phlebotomy service to all patients.

The practice allow a community psychologist the use of a clinical consultation room once a week.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 8.00am to 6.30pm daily. Pre-booked extended hours appointments were offered Monday through Friday from 6.30pm to 7.10pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

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

- 66% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 33% of patients said they could get through easily to the practice by phone compared to the CCG average of 67% and the national average of 71%.
- 68% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 82% and the national average of 84%.
- 57% of patients said their last appointment was convenient compared with the CCG average of 77% and the national average of 81%.
- 39% of patients described their experience of making an appointment as good compared with the CCG average of 68% and the national average of 73%.
- 39% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 53% and the national average of 58%.

Patients told us on the day of the inspection they had difficulty booking appointments which aligned with patient satisfaction reported in the national GP patient survey results. The practice told us they reviewed the findings of the national GP survey with the PPG once a year to allow the PPG to decide what areas of patient satisfaction the practice should focus on improving. The practice provided evidence of the annual meeting with the PPG with agreed actions for improvement. For example, increasing the number of staff answering the phone during busy times. The practice responded by increasing the number of staff to two during busy periods. Patient satisfaction for accessing practice by phone remained the same from 2016 to 2017.

The practice had a system to assess:

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

The duty doctor was responsible for clinical triage in regards to home visit requests and urgent medical

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

attention requests. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints systems. For example, posters displayed in the patient waiting area, complaints leaflet and on the practice website.

We looked at 10 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, we reviewed a patient complaint about a delayed referral. We reviewed the practice response and found that detailed information had been provided to the patient along with a comprehensive explanation and an apology. The practice provided information on the patient's rights when making complaint and where they could escalate the issue if they felt it had not been resolved appropriately by the practice.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice was unable to provide evidence of a clear strategy and supporting business plans which reflected the vision and values were regularly monitored.

Governance arrangements

There were systemic weaknesses in governance systems such as ineffective monitoring of procedures.

- There was a lack of clarity around key roles in the staffing structure. For example, we were told that the practice nurse role was effectively a healthcare assistant position. The information provided on the day of inspection contradicted this description as we were informed that the practice nurse provided child immunisations, spirometry testing and was a cervical screening sample taker. We were also told that only the GPs at the practice managed patients with long term conditions, however the practice website stated that the asthma clinic was nurse led.
- We were told that a comprehensive understanding of the performance of the practice was maintained however some information we received at the inspection did not align with this statement. For example, we were told by the partners that the clinical exception reporting rate for 2016/17 was four percent. However, data published for 2016/17 stated that the clinical exception reporting rate for the practice was 15%.
- We were told there was a programme of continuous clinical and internal audit used to monitor quality and to make improvements. We were provided with seven clinical audits; however none of these were completed two cycle audits. Following the inspection a second cycle was completed and submitted in relation to cervical screening, the findings of this audit are detailed under the 'effective' domain in this report. However, the audit did not demonstrate quality improvement as a result of lessons learned from the first cycle audit.
- We were not provided with evidence of effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, we found that there was no clinical oversight for uncollected prescriptions and the management of high risk medicines presented a significant risk to patient safety. These risks were identified through the inspection, not through the practices own governance processes.
- Practice policies were available to all staff, we saw evidence that new members of staff were informed about where to access and review practice policies. However, we found that practice policy was not always effective. For example, the policy for the management of high risk medicines did not identify what a high risk medicine was, did not include NICE guidance or any other nationally recognised clinical guidance or describe the frequency and type of monitoring required in order to ensure safe management of high risk medicines by clinical staff.
- We found there was an inconsistent process for recording and reviewing patient safety alerts. The practice submitted an audit which outlined the action taken for four patient safety alerts. The audit clearly identified action taken by the practice in relation to the safety alerts. We asked the practice to provide evidence of how they monitored safety alerts and decide which alerts required action to be taken. Apart from the audit, the practice were unable to evidence the process by which alerts were received, recorded and discussed to decide whether they were relevant to the practice and what action should be taken.
- On the day of inspection the practice was unable to provide evidence that they received recent alerts relevant to general practice and reviewed them to decide if action was required. Examples of recent safety alerts that the practice could not provide evidence for was an insulin pen alert issued by the Medicines and Healthcare products Regulatory Agency (MHRA) on 24 August 2017 and an alert for all Accu-Chek® Insight insulin pumps issued by the MHRA on 20 September 2017.
- There was a system in place for reporting and recording significant events and staff understood their responsibilities in relation to reporting significant events. However, when things went wrong lessons learned were not communicated widely enough to support improvement. For example, we reviewed a

Are services well-led?

Inadequate

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

significant event regarding a referral misplaced by the hospital and the practice were unable to demonstrate that they shared learning from the event with the hospital.

Leadership and culture

On the day of inspection we identified a number of concerns around ineffective goverance systems which led to patient safety concerns. When we spoke to the partners about these concerns the partners told us they prioritised safe, high quality and compassionate care. They provided examples such as in-house phlebotomy services for all patients, in-house counselling services one day per week and extended appointments for patients with long-term conditions. The concerns we identified did not align with a leadership structure that had a comprehensive insight as to where improvements were required.

From the sample of eight documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

There was a leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes from these meetings were available for practice staff to view.

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

There was an active patient participation group (PPG) which met once a year. The PPG reviewed the national GP patient surveys and provided suggestions for improvements to the practice management team. For example, the PPG suggested more staff were made available to answer the phone during busy times. The practice responded by increasing the number of staff answering the phones during busy times to two members of staff.

The practice obtained staff feedback through staff meetings, appraisals and discussion. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was some evidence of learning within the clinical team at the practice. For example, the partners invited hospital consultants into the practice to provide learning events for GPs at the practice. The practice provided evidence of the most recent event which was held in March 2017 with a focus on cardiology update.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • We found that you are failing to operate effective systems or processes to ensure good governance in accordance with the fundamental standards of care. This was in breach of regulation 17(1) Good Governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • You are failing to ensure that persons employed in the provision of the regulated activity receive the appropriate support, training and professional development necessary to enable them to carry out the duties. This was in breach of Regulation 18, (2), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 201