Umar Medical Centre

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

Key findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. (Previous inspection July 2016 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires Improvement

Are services responsive? – Inadequate

Are services well-led? - Inadequate

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

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those recently retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

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

We carried out an announced comprehensive inspection at Umar Medical Centre on 7 March 2018 in response to concerns raised by members of the public.

At this inspection we found:

- The practice was negotiating a period of transition with recent changes to the GP partnership and a newly appointed practice manager. The practice had also experienced a turbulent time over recent months with staff absence.
- There was some confusion amongst staff around roles, responsibilities and the staffing structure. We found staff morale was low with limited evidence of a team ethos.
- The practice lacked clear systems to manage risk and mitigate against the repeat of safety incidents. When incidents did happen, we found examples where the practice had not learned from them or improved its processes.
- There was limited evidence of clinical audit or quality improvement to demonstrate the effectiveness and appropriateness of the care provided.
- Staff delivered care and treatment according to evidence-based guidelines.

Summary of findings

- The practice demonstrated an awareness of the patient population it served and took pride in being integrated into the local community. The GPs delivered healthcare awareness sessions at the local mosque and schools.
- We found significant gaps in governance arrangements. There were gaps in practice policies and procedures to govern key activities.
- The practice was unable to evidence that an infection prevention and control audit had been completed.
- There was a lack of managerial oversight of training and staff training needs. Appraisals for staff had not been completed regularly.
- Information flow within the practice was largely informal. The practice lacked a meeting structure to formally document the dissemination of any changes to staff.
- Patients rated the practice lower than others for many aspects of care, although patients told us staff involved and treated them with compassion, kindness, dignity and respect.
- Patients found the appointment system confusing to use and reported that they could not always access care when they needed it.
- The practice lacked a systematic approach to managing and responding to patient complaints.
- There was confusion and dysfunction in how the practice managed incoming post.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure there is an effective system for identifying , receiving ,recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Work should continue to identify and support patients who are also carers.
- Undertake activity to proactively promote uptake of breast and bowel cancer screening.

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

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

Summary of findings

The six population groups and what we found

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

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

Umar Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Umar Medical Centre

Umar Medical Centre is a GP practice registered with CQC under a partnership of Drs Anwar and Sarah Alam. A third GP partner, Dr Mohammed Alam, had joined the practice in April 2017, but at the time of our inspection had not been added to the CQC provider registration. It is a single location registered at the main site (3 Lime Street, Blackburn, BB1 7EP) with a branch surgery situated in Darwen (42 Railway Road, Darwen, BB3 2RJ). This inspection visited the main site only. The main site is situated in a residential area close to the centre of the town. There is limited on-street parking.

The practice delivers primary medical services to a list size of approximately 8100 patients under a personal medical services (PMS) contract with NHS England, and is part of the NHS Blackburn with Darwen Clinical Commissioning Group.

The average life expectancy of the practice population is in line with the local and slightly lower than national averages (76 years for males and 81 years for females, compared to 79 and 83 years nationally).

The practice delivers services to a patient cohort consisting of 69% black and ethnic minority (BME) groups. The practice caters for a lower proportion of patients over the age of 65 years (7%) and 75 years (3%) compared to local (14% and 6% respectively) and national averages (17% and 8% respectively). The practice has a higher proportion of younger patients under the age of 18 years (33%, compared to 25% locally and 21% nationally). The practice also caters for a lower percentage of patients who experience a long standing health condition (43%, compared to the local and national averages of 54%).

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is staffed by three GP partners (two males and one female) and a further three salaried GPs (two males and one female). In addition the practice employs an advanced nurse practitioner and two practice nurses. At the time of our inspection the practice was in the process of recruiting a health care assistant. Clinical staff are supported by a practice manager who had been in post since January 2018 and a team of nine administrative and reception staff.

The main surgery is open between 8am and 6.30pm Monday, Wednesday and Friday, 8am and 8pm Tuesday, and 8am and 8.30pm on a Thursday. The branch surgery opens between 8am and 12.30 and then between 2.30pm and 6pm each Monday, Wednesday and Friday and from 8am until 12.30 and 1.30pm until 4.30pm each Tuesday and Thursday. Surgeries are offered throughout the time the practice is open. Extended hours appointments are available on Tuesday and Thursday evenings. In addition, the practice's patients can access extended hours appointments until 8pm on weekday evenings and on weekends at four other local practices. These appointments can be booked through the practice's receptionists and are offered by the local GP federation.

Detailed findings

Outside normal surgery hours, patients are advised to contact the out of hours service by dialling 111, offered locally by the provider East Lancashire Medical Services.

The practice had previously been inspected on 27 July 2016, when a full comprehensive inspection was completed. Following this inspection the practice was rated good overall.

Inadequate

Are services safe?

Our findings

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

The practice was rated as inadequate for providing safe services because there was a dysfunctional system for managing incoming correspondence to the practice, learning from significant events was not implemented effectively and there were gaps in the management of risk.

Safety systems and processes

The practice had some systems to keep patients safe and safeguarded from abuse, although we noted these systems were not always comprehensive.

- The practice had a suite of safety policies including adult and child safeguarding policies which were marked as being regularly reviewed. However, not all staff we spoke with were aware of their location, and we found sections of the safeguarding children policy which had not been made practice specific.
- There was a system to maintain a risk register of vulnerable patients.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- Most staff had received up-to-date safeguarding and safety training appropriate to their role. However, the practice was not able to evidence that the GP safeguarding lead had completed safeguarding children training to the required level three. The practice manager was also aware that some staff were overdue refresher training in safeguarding, as per the practice's policy, which stated training should be completed every three years. Staff knew how to identify and report concerns, and the GPs were able to describe examples where they had liaised with social services to ensure vulnerable patients received appropriate support. Staff who acted as chaperones were trained for the role and had received a 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).
- We saw the practice had carried out staff checks, including checks of professional registration where relevant, on recruitment of permanent members of staff. Disclosure and Barring Service (DBS) checks were undertaken where required. However, we did note that the practice had no documented evidence of conduct in previous employment for a locum GP working in the practice on the day of inspection, nor evidence of safeguarding and basic life support training completed.
- The system to manage infection prevention and control (IPC) was not thorough. We asked to view the most recent IPC audit the practice had completed but no such audit could be located by practice staff. The practice's IPC policy stated that IPC inspections would be completed at least every two months, but there was no evidence of this.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were not adequate systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. However, there was a lack of clarity around both clinical and non-clinical staff roles and responsibilities, with several staff telling us they were unaware of roles carried out by their colleagues, in particular in relation to the management of incoming correspondence to the practice. We were therefore not assured there was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods. We saw a lack of appropriate knowledge and skill mix amongst staff to provide flexibility and cover.
- There was an induction system for new staff tailored to their role. However, staff informed us this was not always sufficient to provide adequate training in order to become competent and autonomous in the role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

Information to deliver safe care and treatment

We were not assured staff always had the information they needed to deliver safe care and treatment to patients. The practice did not have thorough systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, at the time of our inspection the practice did not have a documented procedure for the management of incoming correspondence. Staff we spoke with were unclear as to how this was done, with contradictory descriptions being offered. A number of staff informed us that incoming mail was triaged by non-clinicians, with some filed straight into the patient record without a clinician having sight of it and no audit of this process.

During the inspection we found a backlog of 149 patient letters stored electronically which were showing on the practice's electronic system as not being actioned. We saw examples of these which dated back to June 2017. However, we reviewed a sample of these and corroborated in the patient's records that any necessary action had been completed. The practice provided assurance following the inspection that these letters logged on the system had been cleared, with all appropriate actions completed as necessary.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed its antibiotic prescribing and taken some action to support good antimicrobial stewardship in line with local and national guidance. The practice was working with the clinical commissioning group's medicines management team to further improve this.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in reviews of their medicines.
- Prescribing data for the practice for 01/07/2016 to 30/06/2017 showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group was better than local and in line with national averages; 1.05, compared to 1.24 locally and 0.9 nationally. (This data is used nationally to analyse practice prescribing and Hypnotics are drugs primarily used to induce sleep.)
- Similar data for the prescribing of antibacterial prescription items showed that practice prescribing was slightly above local and national levels; 1.22 compared to 1.11 locally and 0.98 nationally.
- The percentage of antibiotic items prescribed by the practice that were Co-Amoxiclav, Cephalosporins or Quinolones (antibiotics which work against a wide range of disease-causing bacteria) was 6.8%, compared to the local average of 7% and national average of 8.9%.

Track record on safety

The practice needed to improve its systems around safety.

There were comprehensive risk assessments in relation to safety issues, however they had not been reviewed in a timely manner. For example, fire risk assessments had been completed for both the main and branch sites, dated August 2010 and June 2010 respectively. These documents stated they should be reviewed when any changes were made to the premises, or at least every three years. However, during the visit the practice could not demonstrate that a review of the risk assessments had been undertaken. The practice was unable to evidence that the recommended mitigating actions identified in the risk assessments were routinely undertaken. For example, the practice was unable to evidence that monthly testing of emergency lighting was carried out in line with the recommendation of the fire risk assessments. The documents also stipulated that annual tests of the fire alarm should be completed, but the practice could only evidence this was last carried out on 24 June 2016.

Inadequate

Are services safe?

After the inspection, the practice was able to provide an additional fire risk assessment dated March 2014 for the main site. This included an action plan. However this action plan had not been updated to document any action completed as a result.

A legionella risk assessment was documented for the main site, dated April 2014 (legionella is a term for a particular bacterium which can contaminate water systems in buildings). This risk assessment stated it should be reviewed after two years. This review had not been undertaken. A legionella risk assessment at the branch site had been completed in May 2016. Both legionella risk assessments recommended regular flushing from water outlets at specified temperatures. The practice manager confirmed to us that this had not been done.

Lessons learned and improvements made

The practice did not have an adequate system in place to learn and make improvements when things went wrong.

- Systems in place for recording and acting on significant events and incidents were not adequate. Processes in place for reviewing and investigating when things went wrong presented risk that incidents could be repeated. The practice provided us with a summary of eight significant events logged and investigated in the previous 12 months. However, during the inspection we found evidence of a further incident which had not been written up and logged as such, involving a staff member working outside their competencies. While the practice had taken action, it had not been logged and treated as a significant event analysis (SEA), as the practice had been advised to do by their medical defence insurance provider. There was no evidence of shared learning amongst the wider staff group.
- We noted a trend of four SEAs logged between June and July 2017 all relating to the management of incoming correspondence to the practice and associated medication errors. We viewed the documentation relating to two of these SEAs, which indicated that at the time a healthcare assistant (HCA) employed at the practice had responsibility for triaging incoming correspondence and deciding which letters the GPs needed sight of. The documentation of the SEAs indicated actions which needed implementing in order to mitigate against the incidents being repeated. These actions included staff attending workflow optimisation training and undertaking a letter-reading audit to facilitate clinical oversight by the GPs of the management of letters in the practice. We found no evidence that any such audit had been completed. While the HCA and practice manager had attended workflow optimisation training, neither were employed by the practice any longer. At the time of our inspection the practice did not have a documented procedure for the management of incoming correspondence.
- There was little evidence of the outcomes of incident investigations being shared with the wider staff in order to maximise learning. Staff we spoke with were unable to give us examples of recent SEAs and minutes from meetings where we were told they were discussed were not available for the inspection team to view during the visit. After the inspection the practice provided copies of two meeting agendas dated July 2017 and informed us the SEA documentation from a number of previous incidents constituted the minutes of these meetings.
- We asked to view documentation relating to an SEA logged in March 2017 relating to a cancer diagnosis, however documentation could not be located by practice staff during the inspection.
- The system for receiving and acting on safety alerts was not comprehensive. The practice did not maintain an audit trail of any required actions taken on receipt of such alerts, and we found two examples of relevant alerts that the GPs had not had sight of.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

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

The practice was rated as inadequate for providing effective services because there was limited evidence of quality improvement work including clinical audit, a lack of managerial oversight of unmet training needs amongst non-clinical staff and the potential for poorly coordinated care as a result of poor information flow within the practice.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. Clinicians attended the twice yearly 'hot topics' learning events arranged by the clinical commissioning group (CCG). We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

We reviewed evidence of practice performance against results from the national Quality and Outcomes Framework (QOF) for 2016/17 and looked at how the practice provided care and treatment for patients (QOF is a system intended to improve the quality of general practice and reward good practice.)

Older people:

- The practice had not used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Some patients living with frailty had been identified by the local palliative care service and the practice was aware of these patients.
- The practice liaised regularly with the lead doctor from the local hospice to ensure the needs of patients nearing the end of life were met appropriately.
- The practice had identified four patients on its palliative care register.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice lacked a systematic approach to following up patients who had received treatment in hospital or through out of hours services.
- Blood measurements for diabetic patients (HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 86% of patients had well controlled blood sugar levels compared with the CCG and national averages of 80%. However, the practice exception reporting rate for this indicator was 22%, compared to the CCG average of 13% and national average of 12%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).
- The percentage of diabetic patients for whom the last blood pressure reading was 140/80mmHg or less was 90%, compared to the CCG average of 79% and national average of 78%. However, the practice exception reporting rate for this indicator was 22%, compared to the CCG and national averages of 9%.
- The practice employed a GP with special interest in diabetes for one session per week to cater for the needs of more complex diabetic patients.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given had achieved the targeted 90% in three of the four indicators for vaccinations given to children under the age of two years. The percentage of one year old children with the full course of recommended vaccines in 2016/17 was 86%.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice hosted clinics run by the midwife twice per week.
- The GPs met with the health visitor on a monthly basis to discuss patients and ensure care was coordinated.

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

- The practice's uptake for cervical screening was 49%, which was significantly below the CCG average of 69% and national average of 72%. The practice was aware of this low uptake and had recently increased nursing capacity in an effort to address it. The practice informed us that the local GP federation had recently started offering targeted weekend clinics where cervical screening was available for the practice's patients. In the first two months since they commenced, these clinics had completed 81 smear tests.
- The practices' uptake for breast and bowel cancer screening was lower than the national average. For example, 28% of patients aged between 60 and 69 had been screened for bowel cancer within six months of invitation, compared to the CCG average of 51% and national average of 54%. The percentage of females aged between 50 and 70 screened for breast cancer within six months of invitation was 47%, compared to the CCG average of 56% and national average of 62%.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. We noted the practice had identified four patients on its palliative care register. The GPs felt this number was low due to coding issues on the electronic patient record system. The practice worked closely with the doctor from the local hospice to ensure the needs of patients nearing the end of life were best met.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

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

- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months, compared to the CCG and national averages of 84%.
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months, compared to the CCG average of 93% and national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 94% of patients experiencing poor mental health had received discussion and advice about alcohol consumption, compared to the CCG average of 94% and national average of 91%.
- The practice did not document care plans for patients diagnosed with dementia.
- Patients with complex mental health needs were offered an annual review and were signposted to the local 'well-being' service which offered counselling support.

Monitoring care and treatment

The most recent published QOF results achieved by the practice were 98.5% of the total number of points available compared with the CCG average of 98.3% and national average of 96.5%. The overall exception reporting rate was 18.7% compared with a CCG average of 11.1% and national average of 9.6%. In particular, the practice's exception reporting for diabetes indicators was higher than local and national averages. We saw that the practice was utilising exception reporting appropriately in the sample of records we reviewed. The GPs informed us they expected the current year's QOF performance to be lower due to the staffing issues the practice had experienced over the previous 12 months.

The practice did not have a comprehensive programme of quality improvement activity and did not share evidence with us demonstrating it routinely reviewed the effectiveness and appropriateness of the care provided. Limited evidence was available of clinical audit, where changes made were revisited and evaluated for effectiveness. The practice shared a summary document indicating three audits had been commenced. One was

Inadequate

Are services effective?

(for example, treatment is effective)

dated as 2015/16 (prior to our previous inspection) examining the diagnosis of uncomplicated urinary tract infections (UTI). This summary indicated the practice was mostly diagnosing UTI in line with Public Health England guidance, and that the guidance was circulated to clinicians in an effort to prompt further improvement in this area. A joint injection audit summary dated 2015/16 and 2016/17 suggested there were no patients suffering post-operative complications. The summary document also referenced an undated audit commenced examining the recording of blood pressure checks for patients receiving hormone replacement therapy. The write up indicated that nine patients had been identified as needing to be called in to see the healthcare assistant in order to have their blood pressure checked. The GPs informed us these patients were recalled to the practice, but this had not been documented as part of the audit documentation shared with us.

After the inspection the practice provided a further more recent audit cycle following up on the diagnosis of UTI which indicated compliance with guidance had improved from 80% to 85%.

Effective staffing

Clinical staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. However, we spoke with non-clinical staff who felt there were unmet training needs amongst this group, with the high turnover of reception and administration staff contributing to a lack of confidence in autonomous working.

- The practice could not demonstrate it had an up to date understanding of the learning needs of staff. There was a lack of managerial oversight of training; for example the practice manager informed us the practice's training matrix was not fully up to date.
- We saw some evidence the practice provided staff with ongoing support. For example, the newly appointed nurse practitioner had met with one of the GPs to ensure appropriate coaching, mentoring and oversight of their clinical decision making including non-medical prescribing was in place. However, the practice lacked a systematic approach to ensuring non-clinical staff had access to appraisals as a means to monitor performance, development and training needs. Evidence provided by the practice indicated non-clinical staff had not received an appraisal since summer 2016 and staff we spoke with confirmed it had been some time since they were last formally appraised.
- There was a clear approach for managing staff when their performance was poor or variable. We saw evidence the practice liaised with its medical defence union to ensure appropriate action was taken. However, we saw an example where this advice had not been followed fully, in that an incident had not been logged fully as a significant event.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. However, the lack of clarity around the management of correspondence from secondary care presented the risk of inefficient and disjointed information flow within the practice with regards to the treatment needs of patients.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The practice held six-weekly multi-disciplinary team meetings to discuss patients with more complex needs. However, the minutes we viewed of these meetings did not indicate which professionals had attended. Following the inspection, the practice sourced an attendance list for the most recent of these meetings from the locality team co-ordinator who arranged them, and shared this with the inspection team.
- 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.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives and patients at risk of developing a long-term condition.

Inadequate

Are services effective?

(for example, treatment is effective)

- The percentage of new cancer cases who were referred under the two-week-wait referral pathway was above local and national averages (75% compared to 50% locally and 52% nationally).
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Requires improvement

Are services caring?

Our findings

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

The practice was rated as requires improvement for providing caring services due to poor patient satisfaction and the lack of a coordinated approach to identifying and supporting patients identified as carers.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private space to discuss their needs.
- Of the 17 patient Care Quality Commission comment cards we received, 14 were positive about the service experienced. Comments indicated many patients felt listened to, with two of the cards naming specific clinicians to praise the care and treatment they offered. Three comment cards we received raised some concerns about the practice. These concerns related to access to the service, the timeliness of treatment and the attitude of staff.

Results from the July 2017 annual national GP patient survey showed patients mostly felt they were treated with compassion, dignity and respect. A total of 388 surveys were sent out and 103 were returned. This represented a response rate of 27% and was about 1% of the practice population. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 96%.
- 78% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 87%; national average - 86%.
- 79% of patients who responded said the nurse was good at listening to them; CCG - 91%; national average - 91%.
- 75% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 49% of patients who responded said they would recommend the practice to someone who had just moved to the local area; CCG – 81%; national average – 79%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care:

- Many staff were multi-lingual and interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Practice staff experienced difficulty during the inspection interrogating the practice's electronic record system to tell us how many patients it had identified as carers. We were told by the GPs that the practice did not maintain a carers' register, with the suggestion that they were not fully coded on the electronic record system. However, five days after the inspection the practice supplied evidence demonstrating that 58 patients had been identified as carers (0.7% of the practice list). The GPs informed us the practice did not have a nominated staff member to act as carers' champion, and were unaware of any specific support available for carers locally. We did note information leaflets for carers in the patient waiting area.

The GPs told us that if families had experienced bereavement, their usual GP contacted them by telephone. This call was followed by a patient consultation at a flexible time and location to meet the family's needs as necessary.

Requires improvement

Are services caring?

Results from the national GP patient survey showed patients mostly responded positively to questions about their involvement in planning and making decisions about their care and treatment. However, results were lower than local and national averages:

- 76% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 86%.
- 69% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 84%; national average - 82%.
- 74% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 90%; national average - 90%.
- 71% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice was aware that conversations with receptionists could be overheard by patients in the waiting room; the practice planned to redesign the reception area to address this in the near future.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

The practice was rated as inadequate for providing responsive services because patients found it difficult to access the service and the practice did not have a comprehensive system in place for managing patient complaints.

Responding to and meeting people's needs

The practice told us it aimed to organise and deliver services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours, online services such as repeat prescription requests and advanced booking of appointments.
- We saw that the practice was integrated into the local community; one of the GPs had run health promotion and awareness sessions at the local mosque and schools.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services, for example by offering home visits where necessary.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice held regular meetings other professionals to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The GPs told us children who arrived late for their appointment were always seen by the clinician.
- The practice was aware of the tendency of the local population to bring multiple family members to a single appointment, and so had built in 'blocks' to the appointment system to accommodate this, saving multiple trips to the practice for the family and ensuring all patients' needs were met.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and online facilities.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Patients with complex needs were offered longer appointments.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held a register of patients who had dementia and of those who had complex mental health needs.

Timely access to care and treatment

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Some patients expressed frustration and felt they were not able to access care and treatment from the practice within an acceptable timescale for their needs. Three of the patient comment cards returned and one patient we spoke with on the telephone told us the appointment system was confusing. We were given examples by patients where they were told different information regarding appointment availability and the booking process by different members of practice staff. They also told us the practice could be very difficult to contact by telephone.

The practice was aware of the high proportion of appointments where patients failed to attend (approximately five per day of the 30 urgent on the day appointments offered) and was planning to shortly introduce measures to address this. For example, a demonstration of a text messaging reminder service had been arranged for two weeks after our inspection, with a view to the practice commencing its use.

Patients with the most urgent needs had their care and treatment prioritised. The GPs informed us that they ensured children were seen the same day, and would always be seen if they arrived late for their appointment.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was lower than local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 63% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 83% and the national average of 80%.
- 35% of patients who responded said they could get through easily to the practice by phone; CCG – 71%; national average - 71%.
- 46% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 76%; national average - 76%.
- 70% of patients who responded said their last appointment was convenient; CCG - 81%; national average - 81%.
- 40% of patients who responded described their experience of making an appointment as good; CCG - 76%; national average - 73%.
- 29% of patients who responded said they don't normally have to wait too long to be seen; CCG - 61%; national average - 58%.

The practice were aware of these low results, and felt the recruitment of additional clinical staff and resulting increased clinical capacity would improve patient access.

Listening and learning from concerns and complaints

The practice's system for managing patient complaints was not adequate. The practice had logged six complaints received in the previous 12 months. We saw information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately. The practice's complaint policy and procedures were in line with recognised guidance.

We reviewed two complaints and we were unable to verify they had been satisfactorily handled due to gaps in documentation the practice held regarding the complaints. For example we asked to view documentation relating to one complaint logged on the practice's summary sheet dated July 2017. We saw the practice's written response to the complaint dated 6 October 2017. However, the practice was unable to locate the original complaint letter from the patient. The second complaint we viewed was dated 11 August 2017. The practice had responded in writing on 21 August 2017. We noted the practice's response did not signpost the patient to the Parliamentary Health Service Ombudsman should they wish to escalate their complaint if they were unhappy with the practice's response. We noted the patient had lodged a follow up complaint with the practice on 5 September 2017 as they were unhappy with the practice's original response. The practice could not evidence during the inspection that it had responded to this second letter. After the inspection, the practice was able to locate the letters relating to the complaints.

Are services well-led?

Inadequate

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

Our findings

We rated the practice and all of the population groups as inadequate for providing a well-led service.

The practice was rated as inadequate for well-led because the governance structure did not provide adequate systems and processes to ensure safe and effective care.

Leadership capacity and capability

The practice leadership structure was in a period of transition, with new GP partners and practice management since our previous visit. At the time of our inspection the practice found it difficult to evidence that leaders had the capacity and skills to deliver high-quality, sustainable care. We noted that the practice leadership was working within a number of constraints, including for example those caused by staff absence and turnover. We saw that the newly appointed practice manager was experienced and had been recruited from a credible professional background within primary care. However, they had not yet been in post sufficient time to implement and embed required changes.

Leaders demonstrated some knowledge about issues and priorities relating to the quality and future of services. There was some understanding of the challenges and an action plan had been formulated to work towards addressing them. This action plan addressed topics such as patient satisfaction and the low uptake of cervical screening.

Vision and strategy

The practice was developing a vision and strategy to improve the quality and sustainability of care.

- There was a clear vision and set of values. The practice was committed to providing patient centred care within the community.
- The practice lacked a formally documented long term business plan to support the vision and strategy.
- Staff were aware of the patient centred values of the practice and of their role in achieving them.

Culture

The practice was working to embed a culture of high-quality sustainable care.

- An ethos of team work was not embedded in practice. Some staff disclosed to us that staff morale was low.
- We saw some examples where leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- We saw examples where openness and transparency had not been fully demonstrated when responding to incidents and complaints.
- Staff we spoke with told us they were aware of how to raise concerns. However, staff were less clear about how they would receive feedback regarding how any such concerns had been addressed.
- Processes for providing all staff with the development they needed, including appraisal and career development conversations were not thorough. The practice was unable to demonstrate that non-clinical staff had received appraisals in the last year.
- Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were given some protected time for professional development and evaluation of their clinical work, although this was not always sufficient.
- There had been a high turnover of staff in recent months.
- The practice actively promoted equality and diversity. The training matrix indicated staff had received equality and diversity training.

Governance arrangements

There was a lack of clarity around responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were not set out, understood or effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were not clear on their roles and accountabilities including in respect of key practice processes related to information flow within the organisation and infection prevention and control.

Are services well-led?

Inadequate

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

- Practice leaders had not established proper policies, procedures and activities to ensure safety and had not assured themselves that key activities undertaken were operating as intended. For example, the practice did not have a documented protocol for the management of incoming correspondence at the time of inspection, and an audit of this activity had not been completed despite the outcome of a significant event stipulating that this should be done.
- We saw examples of practice policies, dated as reviewed in February / March 2018, which contained inaccurate or outdated information. For example, the chaperone policy referred to the PCT (the Primary Care Trust which had ceased to exist in 2013).
- The practice lacked a clear meeting structure as means of formalising dissemination of information to the staff team. Staff confirmed to us they had not attended staff or team meetings for some time. The lead receptionist at the branch site worked only at that premises so had limited contact with the rest of the staff team.

Managing risks, issues and performance

The practice lacked clear and effective processes for managing risks, issues and performance.

- The process to identify, understand, monitor and address current and future risks including risks to patient safety was not comprehensive.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. However, there were unmet training needs amongst non-clinical staff. For example, on the day of inspection staff had considerable difficulty interrogating the electronic patient record system in order to run searches.
- Practice leaders lacked appropriate oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit was not embedded into practice. The practice was unable to evidence that changes to clinical processes as a result of audit had a positive impact on quality of care and outcomes for patients, as they had not been routinely revisited for evaluation.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice could not always clearly demonstrate how it acted on appropriate and accurate information.

- We were not assured that information from secondary care providers (for example from hospital appointments) was always seen and acted on in a timely manner; the practice had failed to implement an effective system.
- We did not see evidence during the inspection that quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. We were told by the practice manager and GPs that such information was discussed at meetings held at the GPs' houses, involving only the partners and were not minuted. However, after the inspection the practice provided minutes of a business meeting held on 9 January 2018.
- Quality and operational information was not effectively used to ensure and improve performance.
- The information the practice told us it used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address some of the identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care, although some staff were not proficient in the use of the electronic patient record system.
- The practice submitted data or notifications to external organisations as required.

Engagement with patients, the public, staff and external partners

The practice was attempting to involve patients, the public, staff and external partners to support high-quality sustainable services.

- The practice was aware of the below average patient feedback from the GP patient survey, and hoped the recent increase in clinical capacity at the practice would improve patient experience.

Are services well-led?

Inadequate

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

- The practice manager informed us the patient participation group had lapsed and was no longer active, but they were working to reinstate it.
- The service was transparent, collaborative and open with stakeholders about performance. We saw how the practice had engaged with a recent quality visit from the CCG.

Continuous improvement and innovation

There was some evidence of systems and processes for learning and continuous improvement.

- The practice was engaging with a local initiative around care navigation in order to better inform patients of the best avenues to access care and treatment required.
- The practice had been successful in a bid for funding for a GP assistant's post which would create a single point of contact within the practice team for patients with longer term health needs.

However, the practice needed to make better use of internal and external reviews of incidents and complaints. Learning was not shared effectively to make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. For example, we found examples where either the original complaint letter from a patient, or response letter from the practice were not available for us to view. This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services 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 registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular, documented mitigating actions following analyses of incidents had not been completed. These actions related to the safe management of incoming correspondence to the practice. At the time of our visit there were 149 letters flagged on the patient record system as not having been actioned. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were insufficient systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. For example, there was no documented audit trail of actions completed on receipt of patient safety alerts. Risk assessments, such as for fire and legionella, were out of date and recommended mitigating activities had not been completed. The practice was unable to evidence that an infection prevention and control audit had been completed. The practice lacked thorough

This section is primarily information for the provider

Enforcement actions

processes to effectively disseminate learning following incidents. The practice could not evidence the GP safeguarding lead had completed required training in this area.

There were insufficient systems or processes that ensured the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular we saw no documentation of evidence of conduct in previous employment for a locum GP working in the practice during the inspection.

There were insufficient systems or processes that enabled the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular we found many staff had not received an appraisal for almost two years.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.