The Pinner Road Surgery

Quality Report

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Harrow
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Date of inspection visit: 7 June 2016
Date of publication: 07/12/2016

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 The Pinner Road Surgery on 7 June 2016. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe and being well led. It was also inadequate for providing services for; older people, people with long-term conditions, families, children and young people, working age people, people whose circumstances make them vulnerable and people experiencing poor mental health. Improvements were also required for providing responsive and effective services. It was good for providing caring services.

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There was no induction programme for non-clinical staff and there was no evidence they had been given information on safeguarding, infection control, fire safety, health and safety and confidentiality when they first started working at the practice.
- Not all staff had training to recognise or respond appropriately if they suspected abuse had occurred and the practice did not have formal policies for staff to follow.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Patients said they were involved in their care and decisions about their treatment.

Summary of findings

- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- Practice specific policies were not implemented and were not available to all staff, this meant that staff were not always aware of what process to follow if something went wrong.
- There was a no formal system for recording and analysing complaints.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

The areas where the provider must make improvements are:

- Introduce clear and effective processes for reporting, recording, acting on and learning from significant events, incidents and near misses.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Implement a system for clinical audits including re-audits to ensure improvements are identified and achieved.
- Provide staff with appropriate policies, guidance and training to carry out their roles in a safe and effective manner so that they can safely and effectively meet the needs of the patients.
- Ensure that there is a formal system in place for recording andcomplaints.
- Ensure that there is an effective process in place for staff appraisal to be undertaken on a regular basis, for staff to access training and a system for induction for new staff
- Ensure that DBS checks are undertaken as part of the recruitment process for all staff employed at the practice or a risk assessment to indicate the risks of not having one have been assessed.

The areas where the provider should make improvement are:

- Improve the care of patients with asthma.
- Update polices and processes to improve screening uptake for cervical cytology.
- Amend the process for recording discussions of internal meetings
- Revise arrangements in place to ensure that patients with caring responsibilities are identified, so their needs are identified and can be met.

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.

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.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not undertaken and lessons learned were not communicated to support improvement. Patients received a verbal apology, however, these discussions were not recorded.
- Patients were at risk of harm because systems and processes were not in place.For example, appropriate risk assessments were not implemented, including but not limited to; fire safety, health and safety, hazardous substances, electrical equipment and legionella.
- There was insufficient attention to safeguarding children and vulnerable adults. Not all staff had training to recognise or respond appropriately if they suspected abuse had occurred and the practice did not have formal policies for staff to follow.
- Some arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.However, there was limited management capacity to deal with day-to-day issues, as the position of practice management was vacant and a suitable replacement had not been appointed.
- There was no induction programme for non-clinical staff and there was no evidence they had been given information on safeguarding, infection control, fire safety, health and safety and confidentiality when they first started working at the practice.

Are services effective?

Requires improvement

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

- Data showed patient outcomes were below the local and national average for mental health indicators.
- Data showed patient outcomes were comparable to the local and national average for diabetes indicators.
- There was no evidence that audit was driving improvement in patient outcomes.
- There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patient needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice as comparable to the local and national average for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they felt cared for, supported and listened to.
- Information for patients about the services was available, easy to understand and accessible.
- We saw that staff treated patients with kindness and respect, and maintained patient information and confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice worked with the local CCG to provide transport services to and from the practice for patients who have limited access to transport services.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

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

- The practice had a vision to deliver care and promote good outcomes for patients; however, they did not always have the required systems and processes in place to support that vision.
- The practice had a system in place to ensure compliance with the requirements of the duty of candour (the duty of candour is

Summary of findings

a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).The practice did not, however, have systems in place to ensure that the response provided to patients was always recorded.

- There was a leadership structure and staff told us they felt supported by management. However, there was no practice manager to support the partners with day-to-day management of the practice.
- The practice had no policies and procedures to govern activity and staff had no place to reference actions they need to take in response to a range of situations, for example child safeguarding.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings, however, there was no record of discussions taking place during these meetings so staff not in attendance were not kept up to date with discussions and actions.
- Staff told us that the practice had sought feedback from them during ad hoc meetings; however, there was no evidence that the feedback was recorded or acted upon.
- The practice had a patient participation group and sought feedback from them to make improvements for patients.
- Staff told us they had not received regular performance reviews and did not have clear objectives.

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 safety and Well-led, and requires improvement for effective and responsive. The issues identified as inadequate overall affected all patients including this population group:

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety and Well-led, and requires improvement for effective and responsive. The issues identified as inadequate overall affected all patients including this population group:

- Performance for diabetes related indicators was comparable to the local and national average, for instance:
- 71% of patients with diabetes on the register had their blood sugar recorded as well controlled (local average 77%, national average 77%). The exception reporting rate was 6% (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).
- 80% of patients with diabetes on the register had their cholesterol measured as well controlled (local average 80%, national average 81%). The exception reporting rate was 9%.
- 76% of patients with diabetes on the register had a recorded foot examination and risk classification (local average 86%, national average 88%).The exception reporting rate was 4%.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The provider was rated as inadequate for safety and Well-led, and requires improvement for effective and responsive. The issues identified as inadequate overall affected all patients including this population group:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were comparable for all standard childhood immunisations.
- 47% of patients diagnosed with asthma had an asthma review in the last 12 months; this was below the local average of 74% and national average of 75%. This was discussed with the practice during the inspection. The practice have confirmed that they have recruited a new nurse to specifically target and improve upon these results.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- 66% of women aged 25-64 had it recorded on their notes that a cervical screening test has been performed in the preceding five years; this was below the local average of 77% and national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety and Well-led, and requires improvement for effective and responsive. The issues identified as inadequate overall affected all patients including this population group:

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered extended opening hours on Saturday mornings.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety and well-led, and requires improvement for effective and responsive. The issues identified as inadequate overall affected all patients including this population group:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. However, not all staff had received training for them to be aware of their responsibilities in respect of 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 safety and Well-led, and requires improvement for effective and responsive. The issues identified as inadequate overall affected all patients including this population group:

- Performance for mental health related indicators was below the local and national average:
- 60% of patients diagnosed with dementia had a recorded review in a face to face meeting in the last 12 months (CCG average 86%, national average 84%).
- 73% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (CCG average 90%, national average 90%).

Summary of findings

- 84% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the last 12 months (CCG average 91%, national average 88%).
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had an 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 in July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and forty three survey forms were distributed and 101 were returned. This represented 2% of the practice's patient list.

Results from the national GP patient survey showed patients responded positively to questions relating to appointments and access to nurses and GPs. Some of the results were comparable to the local and national averages, for example:

- 70% found it easy to get through to the surgery by phone, (local average 64%, national average 73%).
- 64% were able to get an appointment to see or speak to someone the last time they tried, (local average 70%, national average 76%).
- 74% described the overall experience of their GP surgery as fairly good or very good, (local average 78%, national average 85%).

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards, which were all positive about the standard of care received.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The Pinner Road Surgery

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 practice manager specialist adviser.

Background to The Pinner Road Surgery

The Pinner Road Surgery provides primary medical services in Harrow to approximately 4,273 patients. The practice operates under a Personal Medical Services (PMS) contract and provides a number of local and national enhanced services (enhanced services require an increased level of service provision above that which is normally required under the core GP contract).

The practice population is in the ninth less deprived decile with a low income deprivation.

The practice operates from one site. The building is a purpose built building, over two floors. There is stepped and ramp access to the ground floor waiting area and reception desk. The consultation rooms are all located on the ground floor. In total, there are four consulting rooms.

The practice clinical team is made up of two GP partners (both male and), two GP locums (one female and one male), one practice nurse, one healthcare assistant (HCA), one temporary practice manager, administrative and reception staff.

The practice offers 26 GP sessions per week.

The practice opens between 9.00am and 6.30pm Monday to Friday. Appointments are available between 8.30am and 11:30pm and between 4:30pm and 6:30pm. Extended hours are available on Saturdays between 9:00am and 11:15am.

When the practice is, closed patients can call NHS 111 in an emergency or a local out of hours service.

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

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 and asked other organisations to share what they knew. We carried out an announced visit on 7 June 2016. During our visit we:

- Spoke with a range of staff; three GPs, one practice nurse, one HCA, one temporary practice manager, receptionists and other non-clinical staff.
- Spoke with five patients.

Detailed findings

- Spoke with one PPG member.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 36 comment cards where patients and members of the public shared their views and experiences of the service.

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 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 an informal process in place for reporting and recording significant events.

- Staff informed us that that when things went wrong with care and treatment, patients were informally made aware of the incident and received a verbal apology. There was no written evidence to confirm the discussions that took place between the practice and the patient.
- The practice did not carry out a thorough analysis of the significant events; there was no evidence of discussion taking place and actions taken by the practice to improve the process to prevent the same thing happening again.
- There was no formal policy or incident recording form available. Staff told us they would inform senior managers of any incidents and record the details in an 'incident diary', which was kept in the reception area.We saw an example when a child hit their head against a shelf in the practice; this was recorded in the incident book.Staff informed us that the patient's parent received a verbal apology; however, there was no record of the discussion which took place or any evidence of this incident being discussed with staff or learning shared with all staff.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, for example:

- Some arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. The practice had no policy in place, clearly outlining who to contact for further guidance if staff had concerns about a patient's welfare. There was no lead member of staff for safeguarding. The GPs did, however, attend safeguarding meetings when possible and always provided reports where necessary for other agencies. All (clinical and non-clinical) demonstrated they understood their responsibilities and were aware of what to do if they had a concern; however, non-clinical staff had not received any safeguarding training relevant to their role. Only GPs and nursing staff were trained to child safeguarding level 3 and 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, however, they had not received a Disclosure and Barring Service (DBS) check nor did the practice undertake a risk assessment to demonstrate how the risk of not undertaking a DBS check had been mitigated (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. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, following the recent audit bins in the clinical rooms had been replaced with peddle operated bins.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- We reviewed five personnel files and found recruitment checks, which had been undertaken prior to employment of non-clinical staff to be incomplete. For example, proof of identification, references,

qualifications, registration with the appropriate professional body were all available, however, the appropriate DBS checks had not been undertaken nor did the practice undertake a risk assessment to demonstrate how the risk of not undertaking a DBS check had been mitigated.
- There were systems in place 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were no procedures in place for monitoring and managing risks to patient and staff safety. For example, there was no health and safety policy available, the practice had no up to date fire risk assessments and did not undertake regular fire drills. Electrical equipment was not checked at regular intervals to ensure the equipment was safe to use and clinical equipment was not checked at regular intervals to ensure it was working properly. The practice also lacked other risk assessments to monitor the safety of the premises such as; control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Some arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, there was limited management capacity to deal with day-to-day issues, as the position of practice management was vacant and a suitable replacement had not been appointed.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms that alerted staff to any emergency.
- Non-clinical staff had not received annual basic life support training.
- There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises, it was not battery operated and needed to be plugged in to be operated.
- Oxygen with adult and children's masks was available.
- 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 fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.
- There was no evidence that the practice monitored these guidelines being followed through risk assessments, audits and random sample checks of patient records.

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 were 75% of the total number of points available, with 6% 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). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014 - 2015 showed;

- Performance for diabetes related indicators was comparable to the local andnational average:

- 71% of patients with diabetes on the register had their blood sugar recorded as well controlled (CCG average 77%, national average of 78%).
- 80% of patients with diabetes on the register had their cholesterol measured as well controlled (CCG 80%, national average 81%).
- 86% of patients with diabetes on the register had a recorded foot examination and risk classification .

- The percentage of patients with hypertension having regular blood pressure tests was comparable to the local and national average:
- 78% of patients with hypertension had a blood pressure reading of 150/90mmHg or less (local average 82%, national average 84%).
- Performance for mental health related indicators was below the local and national average:

  • 60% of patients diagnosed with dementia had a recorded review in a face to face meeting in the last 12 months (local average 86%, national average 84%).

  • 73% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (local average 90%, national average 90%).

  • 84% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the last 12 months (local average 91%, national average 88%).

  These figures were discussed with the practice during the inspection. The practice told us that a reason for the low results in mental health indicators was because they have a large migrant population of patients who are not staying with the practice long-term.

  Clinical audits did not demonstrate quality improvement. For example, the practice had shown the inspection team a clinical audit in cytology undertaken in 2015; however, there was no evidence of recommendations made at the end of this audit being implemented by the practice. There had been three other clinical audits undertaken within the last two years, none of which were completed audits where the improvements made were implemented and monitored. The practice also did not participate in local audits, national benchmarking, accreditation, peer review and research.

Effective staffing

Only some staff had the skills, knowledge and experience to deliver effective care and treatment, for example:

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice did not have an induction programme for newly appointed non-clinical staff. There was no record of non-clinical staff receiving induction training to ensure they had formal training about such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, when interviewed staff confirmed that when they first started working at the practice they shadowed a more senior member of the team how explained the process to follow when dealing with issues relating to; safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Clinical staff could demonstrate how they had role specific training, for example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training that had included an assessment of competence. However, these details were not kept by the practice.
- 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.
- Non-clinical staff did not have regular meetings and reviews to help identify their learning needs. Non-clinical staff did not have access to appropriate training to meet their learning needs and to cover the scope of their work. This included lack of ongoing support, one-to-one meetings and coaching and mentoring. Non-clinical staff had not received an appraisal within the last 12 months.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. 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, smoking and alcohol cessation and patients were signposted to the relevant service.
- A dietician was available upon referral and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 66%, which was below the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. There were systems in place 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. These results were discussed with the practice during the inspection; they confirmed that they had recruited a new nurse to specifically target and improve upon the cervical screen results.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening, for example;

- 72% of female patients at the practice aged 50-70 had been screened for breast cancer in last 36 months (local average 71% and national average 72%).
- 50% of patients at the practice aged 60-69 had been screened for bowl cancer within the past 30 months (local average 52% and 58% national average).

Childhood immunisation rates for the vaccines given were comparable to the local average. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 53% to 87% (local 53% to 80%) and five year olds from 55% to 82% (local 60% to 85%).

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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed 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.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 36 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with 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. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to the local and national average for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% said the GP was good at listening to them (local average 86%, national average 88%).
- 87% said the GP gave them enough time (local average 84%, national average 86%).
- 90% said the last nurse they spoke to was good at treating them with care and concern (local average 85%, national average 91%).

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 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. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The practice was comparable to the local and national average, for example:

- 81% said the last GP they saw was good at explaining tests and treatments, (local average 84%, national average 86%).
- 88% said the last nurse they saw was good at explaining tests and treatments (local average 84%, national average 90%).

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

- Staff told us that translation 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.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area that 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's computer system alerted GPs if a patient was also a carer. The practice had identified 30 patients as carers (0.71% of the practice list). The practice used their register to improve care for carers, for example

Good

Are services caring?

carers were offered flexible appointment times and the seasonal influenza vaccine. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card.

This communication 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice worked with the local CCG to provide transport services to and from the practice for patients who have limited access to transport services.

- Extended hours are available on Saturdays between 9:00am and 11:15am.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs that resulted in difficulty attending the practice.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were facilities for people with disabilities, a hearing loop and translation services available.

Access to the service

- The practice opens between 9.00am and 6.30pm Monday to Friday. Appointments are available between 8.30am and 11:30pm and between 4:30pm and 6:30pm.
- In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available on the same day for people that needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to the local and national averages.

- 71% of patients were satisfied with the practice's opening hours (local average 75%, national average 78%).
- 70% patients said they could get through easily to the surgery by phone (local average 65%, national average 73%).
- 27% patients said they always or almost always see or speak to the GP they prefer (local average 26%, national average 36%).

People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns, for example:

- There was no designated responsible person who handled all complaints in the practice.
- Patients were only provided with a verbal response, these discussions had not been recorded by the practice.
- There was no evidence of analysis or learning from complaints.
- There were no posters displayed in the waiting area to help patients understand the complaints system, however, leaflets were available for patients at the reception desk.

We looked at 2 complaints received in the last 12 months and found that lessons were not learnt from individual concerns and complaints. The practice provided patients concerned with a verbal apology; there was no record of the conversations that took place. There was no analysis of trends and no action was taken to as a result to improve the quality of care.

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 had a vision to deliver care and promote good outcomes for patients, however, they did not always have the required systems and processes in place to support that vision, for example:

- The practice had a mission statement that staff were aware of and understood.
- The practice did not have a strategy and supporting business plans which reflected the vision and values and were regularly monitored, for example, the practice did not provide non-clinical staff with basic polices and training required to perform their duties.For example, training for reporting significant events or safe guarding children.

Governance arrangements

The practice did not have appropriate governance arrangements in place which supported the delivery of the strategy and good quality care, for example:

- Practice specific policies were not implemented and were not available to all staff, for example, there was not staff recruitment policy and the practice had not considered whether DBS checks were required.
- A comprehensive understanding of the performance of the practice was not maintained and a programme of continuous clinical and internal audit was not used to monitor quality and to make improvements.For example, clinical audits did not demonstrate quality improvement.For example, there had been four clinical audits undertaken within the last two years, none of which were completed audits where the improvements made were implemented and monitored.The practice also did not participate in local audits, national benchmarking, accreditation, peer review and research.
- There were no robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, For example, patients were at risk of harm because systems and processes were not in place, including but not limited to; fire safety, health and safety, hazardous substances, electrical equipment and legionella.
- Some arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, there was limited management capacity to deal with day-to-day issues, as the position of practice management was vacant and a suitable replacement had not been appointed.

There was, however, a staffing structure and staff were aware of their own roles and responsibilities.

Leadership and culture

On the day of inspection staff told us the partners was approachable and always took the time to listen to all members of staff.

The practice did have a system in place to ensure compliance with the requirements of 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). The practice did not, however, have systems in place to ensure that the response provided to patients was always recorded, for example:

- The practice gave affected people reasonable support, truthful information and a verbal apology.
- Patient complaints and significant events were dealt with informally, with no records being maintained of discussions between the practice and patients, analysis of these complaints/incidents or improvements implemented as a result of these complaints.
- The practice did not hold regular governance meetings, complaints and significant events were discussed at ad hoc meetings.No records were maintained of discussions taking place during these meetings.There was also no evidence of any system to feedback to staff not involved in these ad hoc meetings.

There was a leadership structure in place and staff received some support from management

- Non-clinical staff told us they had not received regular performance reviews and did not have clear objectives; however, they showed awareness of their individual roles and responsibilities.
- Staff said they felt respected, valued and supported by the GP partners in the practice.

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

Are services well-led?

Inadequate

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

The practice collected feedback from patients and staff, for example:

- The practice had gathered feedback from staff generally through ad hoc staff meetings and discussion; however, there was no written record of these meetings or discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- The practice did gather feedback from patients through the patient participation group (PPG) and through surveys, for example, upon the recommendation of the PPG the practice installed a shed for parents and carers to securely leave their pushchairs.

Continuous improvement

There was limited focus on continuous learning and development within the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not have processes for recording and monitoring significant events, incidents and near misses and record safety incidents. The registered person did not ensure that appropriate risk assessments were available. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The registered person did not ensure that there was a system in place for formally recording complaints. This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The registered person did not have system in place to review and analyse complaints and significant events.

The provider did not have quality improvement system to improve outcomes for patients.

The registered person did not provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner that is reflective of the requirements of the practice.

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider could not demonstrate that non-clinical staff were trained to the appropriate level, including but not limited to child protection and basic life support. The provider had not ensured there was an effective process for yearly appraisals to be performed for all practice staff. The provider did not have suitable arrangements for the induction and training of newly recruited staff. This was in breach of regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

The provider had not ensured that all the necessary recruitment checks are undertaken prior to employing staff including Disclosure and Barring Service (DBS) checks or carried out a risk assessment to see if a DBS check was required for staff carrying out chaperoning duties.

This was in breach of regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.