Five Elms Medical Practice

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?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Five Elms Medical Practice on 5 April 2016. Overall the practice is rated as inadequate.

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

- 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 and actions to address concerns with infection control practice had not been taken.
- When there were unintended or unexpected safety incidents, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. People did not always receive a verbal and written apology .
- Improvements to 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.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Take action to assess the risk of, prevent, detect and control the spread of infections.
- Take action to assess the risks associated with fire.
- Carry out a risk assessment to determine if staff who act as chaperones need a DBS check.
- Ensure there is an effective system in place for the receipt and distribution of safety alerts to all staff.

Summary of findings

- Ensure there are processes for identifying where improvements in clinical care can be made and monitored.
- Take effective and sustainable action in response to patient feedback relating to lack access to the service, difficulties obtaining suitable appointments , involvement in decisions about their care and explanations of tests and treatments.
- Ensure that all staff receive training about confidentiality and information governance
- Ensure staff are supported with and receive professional development, supervision, training and appraisal to enable them to undertake their role.
- Provide appropriate training to staff required to carry out chaperone duties.
- Ensure that all staff receive appropriate training on infection prevention and control.
- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.

The areas where the provider should make improvement are:

- Provide staff with appropriate and up to date policies and guidance, which are reflective of the requirements of the practice.
- Review current interpretation services to ensure these are available to patients on request.
- Review arrangements for involving staff in the vision and strategy for the practice and in making improvements in how the practice is run.
- Review the complaints process to ensure it is easily accessible by patients.
- Review arrangements for identifying and supporting carers.

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

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration. Special measures will give people who use the service the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when there were unintended or unexpected safety incidents, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. People did not always receive a verbal and written apology.
- The practice had some systems and processes to keep patients safe but these had weaknesses. For instance, although the practice had a policy for chaperoning, this had not been reviewed since 2012.
- The practice could not demonstrate that staff who acted as chaperones had received a Disclosure and Barring Service check (DBS check) and there was no evidence the practice had carried out a risk assessment to determine if this was needed. (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).
- There was no fire risk assessment and no record of fire drills having been conducted.
- Staff had not received training on infection prevention and control. The practice had not carried out an annual infection control audit since 2012.
- There was no oxygen at the practice at the time of our inspection and the practice were unaware that this was a requirement.
- Appropriate recruitment checks had not been undertaken for all employees.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements must be made.

- The practice had no system to review the training or personal development needs of staff and no system for staff to receive appraisals.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

Summary of findings

- There was no evidence that quality improvement programmes including clinical audit was driving improvement in performance to improve patient outcomes. Patients outcomes were variable when compared to similar services.
- Staff had knowledge of national guidelines but there was no clear process to ensure that these guidelines were consistently monitored and updated.
- The practice used a risk stratification tool to identify and support high risk patients and had identified 8% of it's practice population as being at risk of unplanned admissions to hospital.

Are services caring?

Inadequate

The practice is rated inadequate for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice significantly below others for many aspects of care. For instance, the percentage of respondents who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern was 44% compared to the national average of 85%. The percentage of respondents who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern was 59% (national average 91%).
- There was no evidence that staff had received information governance or confidentiality training.
- There was insufficient information available to help patients understand the services available to them.
- The practice did not have a process for identifying patients who were also carers.

Are services responsive to people's needs?

Inadequate

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

- Data from the National GP Patient Survey showed patients rated the practice significantly below others for many aspects of care. For instance, only 17% of patients said they could get through easily to the surgery by phone (national average 73%), whilst 41% said they were satisfied with the practice's opening hours (national average 84%)
- Patients reported considerable difficulty in accessing a named GP and poor continuity of care. Data from the National GP Patient Survey showed 5% of patients said they always or almost always see or speak to the GP they prefer (national average 36%).

Summary of findings

- Information about how to complain was not easily available for patients although staff told us they would explain the process if they were asked.
- The practice did not have adequate arrangements for patients who did not have English as a first language.
- Repeat prescriptions could be requested in person, through the post or through a community pharmacist. There were no arrangements for online prescriptions.
- Urgent appointments were usually available the same day.

Are services well-led?

Inadequate

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

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- The practice had a number of policies and procedures to govern activity, but these had not been reviewed since 2012 and the practice could not ensure that contact details were current or that policies conformed to current requirements.
- The practice did not hold regular governance meetings and issues were discussed at ad-hoc meetings.
- The practice had not proactively sought feedback from staff or patients.
- Staff told us they had not received regular performance reviews and did not have clear objectives.
- There was no effective system for managing issues and risks arising from inadequate arrangements for chaperoning, safeguarding, fire safety and infection control.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led care. The issues identified as inadequate affected all patients including this population group.

- Although patients aged over 75 were provided with a telephone number which bypassed the main switchboard, data from the National GP Survey showed that only 17% of patients found it easy to get through to the surgery on the telephone (national average 73%).
- The practice had engaged with the Everyone Counts scheme, one part of which aims to improve health outcomes for patients aged over 75.

People with long term conditions

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led care. The issues identified as inadequate affected all patients including this population group.

- Longer appointments and home visits were available when needed.
- Although all these patients had a named GP, data from the National GP Survey showed that only 5% of patients said they always or almost always saw their preferred GP.

Families, children and young people

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led care. The issues identified as inadequate 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.
- The practice's uptake for the cervical screening programme was 70%, which was comparable to the CCG average of 72% and the national average of 74%.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led care. The issues identified as inadequate affected all patients including this population group.

Summary of findings

- Telephone appointments were available for patients who were unable to attend in person or who were unsure if their condition required attention.
- Health checks were available for new patients and those aged over 40 but this was not actively promoted
- The practice did not offer any extended opening hours to support those who worked or had other commitments during the day.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for providing safe, effective, caring, responsive and well-led care. The issues identified as inadequate affected all patients including this population group.

- The practice offered longer appointments for patients with a learning disability.
- There was no access to interpreting services for patients who needed this.
- The practice held a carers register but there were no specific arrangements to support this group of patients and there was no evidence the practice were proactively trying to identify carers.
- The practice worked with multi-disciplinary teams in the case management of vulnerable people but this was generally informal and record keeping was limited.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safe, effective, caring, responsive and well-led. The issues identified as inadequate affected all patients including this population group.

- It had not worked with multi-disciplinary teams in the case management of people experiencing poor mental health.
- Performance data for patients experiencing mental health indicated that most patients had received an annual review but individual care plans were not always produced. For instance, data showed that 97% of patients with schizophrenia, bipolar affective disorder and other psychoses had their smoking status recorded (national average 94%) but only 65% had an agreed care plan.
- Performance data indicated that only 25% of patients diagnosed with dementia had care plans in place. We saw that

Summary of findings

some patient records had been coded incorrectly in this regard and that care plans were in place for patients diagnosed with dementia but the practice was unable to provide data to challenge published performance data.

- The practice had not told patients experiencing poor mental health about support groups or voluntary organisations.
- It did not have a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing significantly below local and national averages. Two hundred and sixty eight survey forms were distributed and 102 were returned. This represented 2% of the practice's patient list.

- 17% found it easy to get through to this surgery by phone compared to a national average of 73%.
- 36% were able to get an appointment to see or speak to someone the last time they tried (national average 76%).
- 37% described the overall experience of their GP surgery as fairly good or very good (national average 85%).
- 22% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (national average 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received one comment card and this referred to poor service, lack of respect and problems accessing appointments.

We spoke with five patients during the inspection. Patients had mixed views about the care they received. Some patients also spoke about difficulties contacting the practice by telephone and problems accessing appointments at times that were convenient. These views aligned with results from the GP National Survey published in January 2016.

Areas for improvement

Action the service MUST take to improve

- Take action to assess the risk of, prevent, detect and control the spread of infections.
- Take action to assess the risks associated with fire.
- Carry out a risk assessment to determine if staff who act as chaperones need a DBS check.
- Ensure there is an effective system in place for the receipt and distribution of safety alerts to all staff.
- Ensure there are processes for identifying where improvements in clinical care can be made and monitored.
- Take effective and sustainable action in response to patient feedback relating to lack access to the service, difficulties obtaining suitable appointments , involvement in decisions about their care and explanations of tests and treatments.
- Ensure that all staff receive training about confidentiality and information governance
- Ensure staff are supported with and receive professional development, supervision, training and appraisal to enable them to undertake their role.
- Provide appropriate training to staff required to carry out chaperone duties.
- Ensure that all staff receive appropriate training on infection prevention and control.
- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.

Action the service SHOULD take to improve

- Provide staff with appropriate and up to date policies and guidance, which are reflective of the requirements of the practice.
- Review current interpretation services to ensure these are available to patients on request.
- Review arrangements for involving staff in the vision and strategy for the practice and in making improvements in how the practice is run.
- Review the complaints process to ensure it is easily accessible by patients.
- Review arrangements for identifying and supporting carers.

Five Elms Medical Practice

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, a practice manager specialist adviser and an Expert by Experience.

Background to Five Elms Medical Practice

Five Elms Medical Practice is a single location practice providing GP primary care services to approximately 4,300 people living in the Dagenham neighbourhood of the London Borough of Barking and Dagenham. The practice is in an area that is in the second most deprived decile. The proportion of patients on the register aged 65 or over is significantly higher than the CCG average. Data from Public Health England shows that 17% of the practice population falls into this age group compared to the CCG average of 9%.

The practice is located in a purpose built health centre which is shared with a dental practice and a team of health visitors. The practice shares reception and waiting areas with these services.

There is one full time GP and one long term part-time locum GP who provide a combined average of 18 sessions per week. There is one part time nurse (0.5 Full Time Equivalent) and four staff who share reception and administration duties. The practice has not had a practice manager since 2015. An experienced member of the administration staff has recently been undertaking some of the former practice manager's duties. A healthcare assistant employed by a local hospital is hired on an hourly basis to undertake NHS health checks.

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

The practice opening hours are 8:30am to 6:30pm Mondays, Tuesdays, Wednesdays and Fridays and Thursdays, 8:30am to 1:30pm. On the first Tuesday of each month, the opening hours are 8:30am to 1:30pm. Surgery times are from 8:30am to 11:30am, Monday to Friday and from 3:30pm to 6:30pm on Mondays, Tuesdays (except for the first Tuesday of each month), Wednesdays and Fridays. There is no surgery on Thursday afternoons or the afternoon of the first Tuesday of each month. Between 8am - 8.30am every weekday and 1:30pm to 6:30pm every Thursday and first Tuesday of every month, telephone calls are answered by a contracted out of hours (OOH) provider.

The practice does not open at weekends, having opted out of providing OOH services. Between 6.30pm and 8.00am and at weekends patients are directed to the OOH provider for Barking & Dagenham CCG. The details of the out of hours service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website.

According to the 2011 national census, Barking and Dagenham is the seventh smallest of London's 32 boroughs in terms of population. It has the highest population percentage of young people aged between 0 and 19 (32%) and the highest percentage of lone parent households with dependent children in England and Wales. The Borough is ethnically diverse and the practice population reflects this diversity. In the latest census in Barking and Dagenham, 58% gave their ethnicity as white, 20% as Asian, 15% as Black African and 7% as mixed or other ethnicity.

Before we undertake an inspection, we ask providers to submit certain information including, summaries of complaints and serious adverse events, numbers of staff by

role as well as details of training and qualifications, recruitment and training policies and evidence of the quality of care for the six population groups we inspect. The practice had not responded to this request.

At the time of our inspection, the practice was incorrectly registered as a partnership and had been so since April 2015 when a GP who had been a partner, left the practice. The practice has made a number of efforts to the cancel the incorrect registration and register as a sole provider but to date has not properly completed the process.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

The practice had not been inspected under the previous inspection methodology.

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 5 April 2016. During our visit we:

- Spoke with a range of staff including a GP, practice nurse, and administrative staff. We also spoke with patients who used the service.
- 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 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

We looked at systems in place for reporting and recording significant events.

- Staff told us they would inform the GP or senior receptionist of any incidents and there was a recording form available on the practice's computer system.
- The GP carried out an analysis of the significant events but lessons learned were not systematically shared with staff.

We saw evidence which showed the practice recorded significant events but there were no records to demonstrate that these had been discussed with staff or that lessons learned had been used to update procedures or protocols. For instance, we saw an incident when a patient's medicine was prescribed in the name of a relative who had requested it on the patient's behalf. The incident had been recorded but there was no record of this being discussed at a meeting and the prescribing protocol had not been updated. There were no records of national patient safety alerts and the practice could not provide evidence of meetings where safety had been discussed.

Overview of safety systems and processes

Although the practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, many of these had not been reviewed since 2012. Not all policies were understood by staff and processes were not routinely followed.

- There was a lead member of staff for safeguarding and the practice described the arrangements in place to safeguard children and vulnerable adults from abuse. When children failed to attend GP or hospital appointments, the practice told us they would always contact the family to ascertain the reason and would follow up on any concerns identified.
- The practice had written policies for safeguarding children and adults but these had not been reviewed since 2012 and the practice were unsure if these reflected relevant legislation and local requirements. Policies were accessible to all staff and these contained contact details for further guidance if staff had concerns about a patient's welfare but the practice was unable to assure us that contact details were up to date
- The GP told us they did not regularly attend safeguarding meetings as these were usually held during surgery hours, but they always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GP's and the practice nurse were trained to Safeguarding level 3, receptionists and administration staff, including the receptionist who was assisting with practice management duties were trained to level 2.
- There was a chaperone policy but this had not been reviewed since 2012. There was no notice in the waiting room or consultation room to advise patients that chaperones were available if required. The GP told us that patients were provided with a chaperone if they requested one. The practice told us that staff who acted as chaperones were trained for the role but had not been risk assessed, nor had a Disclosure and Barring Service (DBS) check completed to check they were safe to do this. (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 asked staff who had acted as chaperones to describe how they had carried out this role but responses indicated that they were unsure of the practice's policy or procedure.
- The GP and practice nurse were the infection control clinical leads. Practice staff had not received infection prevention and control training. The practice had not carried out an annual infection audit since 2012. There was no evidence to indicate that the practice liaised with the local infection prevention teams to keep up to date with best practice. We observed the premises to be clean and tidy, waste was properly segregated, sinks were of a suitable type and were uncluttered. Staff told us they always had enough personal protective equipment (PPE) and we saw that sharps bins were properly labelled and positioned.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Patient Group Directions 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 a range of PGDs and saw that these were within date and were properly managed.

- We reviewed six personnel files and found that appropriate recruitment checks had not been undertaken for all employees. For example, for those staff recruited since 2014, one file did not contain proof of identification, three had no record of references being collected, and four had no record of appropriate checks through the Disclosure and Barring Service and this included the practice nurse.

Monitoring risks to patients

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Risks to patients were not always assessed or well managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available but this had not been reviewed since 2012. There was no information displayed in the reception office which identified local health and safety representatives. The practice did not have up to date fire risk assessments and staff we spoke with told us the practice had not carried out regular fire drills for at least three years. Although there had been no fire drills, staff were able to describe a credible evacuation process which demonstrated knowledge of emergency exits and assembly points.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice was only able to provide evidence of one risk assessment it had in place to monitor safety of the premises and this was for control of substances hazardous to health, but this had not been reviewed since 2012. There were no risk assessments for infection control or legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs but these arrangements had weaknesses. Staff we spoke with told us they were sometimes required to work beyond their contracted hours in order to ensure patients received an adequate standard of care.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- The practice had a defibrillator available on the premises and the batteries and pads were within their expiry dates.
- 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.
- Staff records we saw indicated that some staff had not received any basic life support training since 2011 whilst others had received no training through the practice at all. We asked if these staff had received training externally or in previous employments but were told this was not known.
- There was no instant messaging system on the computers which meant that in an emergency, staff had to communicate by telephone or by moving between rooms to alert staff to any emergency.
- There was no oxygen at the practice at the time of our inspection and the practice were unaware that this was a requirement. We pointed this out to the practice and an order for oxygen was placed immediately and we were provided with evidence that this arrived the day after our inspection. A first aid kit and accident book were available.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage but this had not been reviewed since 2009. Staff were unsure whether emergency contact details were current and the plan included the names of GP partners who had retired several years previously. Staff were unaware how many copies of this plan existed or who held them. We were told the practice had an informal arrangement with a neighbouring practice which involved sharing that practice's building in an emergency.

Inadequate

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 although arrangements to ensure that all clinical staff were up to date with latest guidelines were ad hoc.

- Clinicians organised their own access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. The practice did not however have a system to ensure that these guidelines were followed through risk assessments, audits or random sample checks of patient records.
- Clinicians attended monthly learning sessions organised by the CCG and these included sessions on clinical guidelines, updates and standards.
- The practice used a risk stratification tool to identify and support high risk patients (patients who were at risk of unplanned admissions). The practice had chosen to include a higher percentage than the 2% required by the CCG and had added 8% of the practice population to the register of high risk patients. This practice told us that they had taken this decision based on their knowledge of their population group. Data from Public Health England showed that 17% of the practice population was aged 65 years or over compared to the CCG average of 9%.

Management, monitoring and improving outcomes for people

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 88.6% of the total number of points available.

Data from 2014/15 showed that practice outcomes were variable when compared with other similar services.

- Performance for diabetes related indicators was similar to the CCG and national average. The percentage of patients with diabetes, on the register, whose blood sugar levels were well controlled was 74% compared to the national average of 77%. The percentage of patients with diabetes who had had a recent foot check was 93% (national average 88%).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record was 65% compared to the national average of 90%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had had alcohol consumption recorded was 77% compared to the national average of 88%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review was 25% compared to the national average of 84%.

We asked the practice about the performance data for patients diagnosed with dementia and were told the practice was aware that performance in this area was lower than average and were planning to address this over the following twelve months.

Although performance for some indicators was comparable to or above local and national averages, some indicators also had higher than average exception reporting rates. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The exception reporting rate for diabetes was 18.5% compared to the national average of 10.8% whilst the rate for rheumatoid arthritis was 33% compared to the CCG average of 5%.

We discussed the practice's exception reporting rates with the GP. We were told that an incorrectly low level of HBA1c (a measure of blood glucose levels) had been used to report 'difficult to manage' cases and consequently some patients were excepted who should not have been. This error had been identified and the correct level was now being used. The practice followed standard procedures for exception reporting patients who did not respond to invites for QOF reviews and recorded invites on patient records. Patients who failed to respond after three invites were excepted. The practice told us that their practice was located in an area which was in the second most deprived decile on the IMD scale (Index of multiple deprivation) and that within this area itself, the practice had a high

concentration of patients who were amongst the most deprived on the IMD scale. The practice told us that patients in this situation were often less responsive to invitations to annual reviews.

There was no evidence that the practice undertook quality improvement activity.

- There had been no clinical audits completed in the last two years.
- There was no evidence of participation in local audits, national benchmarking, accreditation, peer review or research.

Effective staffing

Staff we spoke with could demonstrate they had the skills, knowledge and experience to deliver effective care and treatment. However, there were weaknesses in staff training, particularly in the assessment of training needs and ensuring that training was up to date.

- The practice could demonstrate how they ensured role-specific training and updating for clinical staff. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at clinical forums.
- Clinical staff benefitted from one half day of protected learning time each month and used this to attend relevant courses and seminars.
- There was no induction programme for newly appointed staff. Whilst staff were confident and appeared competent in their roles, there was no evidence that they had been provided with training or information on practice policies including infection control, confidentiality or health and safety.
- Staff were not supervised effectively. There was no systematic process for identifying the learning needs of non-clinical staff. There was no system of appraisals, meetings or reviews of practice development needs. We were told that no member of staff, including clinical staff, had received an appraisal for at least two years.
- Staff were not proficient in the use of the practice's computer systems or processes, particularly processes used for analysis and reporting. For instance, no member of the reception or administration teams were able to access or provide information on the practice's current QOF performance.
- Staff we spoke with demonstrated that they understood the principles and practice of information governance but there were no records to indicate that staff had received any formal training in this area.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- There was a manual process for monitoring urgent referrals sent via the two week wait pathway and this was used to ensure that patients received appointments within the two week period.
- The practice made regular referrals to, and held regular meetings with the local Integrated Care Team.

Staff worked together and with other health and social care services 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. We saw evidence that multi-disciplinary team meetings were taking place but this was generally informal and record keeping was limited.

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.

Inadequate

Are services effective?

(for example, treatment is effective)

- 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 practice did not request written consent for vaccinations or immunisations but sought and recorded verbal consent on patient notes.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice's uptake for the cervical screening programme was 70%, which was comparable to the CCG average of 72% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages. They did this using an online translation tool and by signposting patients to the NHS website where information in different languages was available. The practice ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and rates for these programmes were also comparable to local and national averages.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to one year olds ranged from 88% to 91%, two year olds from 72% to 87% and five year olds from 63% to 78%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Inadequate

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.

We asked the practice to provide evidence that staff had received Information Governance or confidentiality training but they were unable to do so. Only one member of staff had signed a confidentiality agreement.

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

Although we generally received positive comments from patients we spoke with on the day, the practice scored significantly below local and national averages for its satisfaction scores on consultations with GPs and nurses from the national GP patient survey:

- 54% said the GP was good at listening to them compared to the CCG average of 81% and national average of 89%.
- 40% said the GP gave them enough time (CCG average 79%, national average 87%).
- 65% said they had confidence and trust in the last GP they saw (CCG average 90%, national average 95%)
- 44% said the last GP they spoke to was good at treating them with care and concern (national average 85% - CCG average unavailable).
- 59% said the last nurse they spoke to was good at treating them with care and concern (national average 91% - CCG average unavailable).
- 52% said they found the receptionists at the practice helpful (CCG average 84%, national average 87%)
- 32% said the last GP they saw or spoke to was poor at listening to them (CCG average 7%, national average 4%)

We discussed these results with the practice. We were told that ongoing efforts to recruit an experienced practice manager and a second GP had so far been unsuccessful. The practice told us this had an ongoing impact on patient satisfaction because of the limited access to a GP and the reduction of resource in the reception team whilst the senior receptionist was undertaking other duties. The practice told us they were continuing to look for new staff but were also now considering other options including developing existing staff.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed patients did not respond positively to questions about their involvement in planning and making decisions about their care and treatment. Results were significantly below national averages. For example:

- 44% said the last GP they saw was good at explaining tests and treatments compared to the national average of 86%.
- 39% said the last GP they saw was good at involving them in decisions about their care (national average 82%)
- 60% said the last nurse they saw was good at involving them in decisions about their care (national average 85%)

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 0.3% of the practice list as carers, however we did not see evidence they were proactively trying to identify carers.Written information was available to direct carers to the various avenues of support available to them. The practice offered carers a priority flu vaccination and would refer carers for counselling when this was suitable.

Inadequate

Are services caring?

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found little evidence the practice had engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. However, there were some examples of where the practice had responded to local needs.

- The practice held a register of patients (37 patients) with a learning disability and longer appointments were available for these patients. Of those patients with a learning disability, 79% had received an annual health check within the past year.
- Home visits were available for housebound patients and other patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities and a hearing loop.
- Staff told us that interpretation services were not available for patients who did not have English as a first language. Some staff told us that they occasionally used an online translation tool to communicate with patients.

Repeat prescriptions could be requested in person, through the post or through a community pharmacist. There were no arrangements for online prescriptions and staff told us they had been instructed not to help patients write their repeat requests. We were told this was to avoid errors.

Access to the service

The practice opening hours, GP and nurse appointment times were as follows:

- Monday

8:30am to 12:30pm and 2:30 to 6:30pm (GP appointments from 8:30am to 11:30am and 3:30pm to 6:30, nurse appointments from 1:30pm to 6:30pm)

- Tuesday (except for first Tuesday of each month)

8:30am to 12:30pm and 2:30 to 6:30pm (GP appointments from 8:30am to 11:30am and 3:30pm to 6:30, nurse appointments from 1:30pm to 6:30pm)

- Wednesday

8:30am to 12:30pm and 2:30 to 6:30pm (GP appointments from 8:30am to 11:30am and 3:30pm to 6:30, nurse appointments from 8:30am to 1:30pm)

- Thursday and first Tuesday of each month

8:30am to 1:00pm (GP appointments from 8:30am to 11:30am, no nurse appointments)

- Friday

8:30am to 12:30pm and 2:30 to 6:30pm (GP appointments from 8:30am to 11:30am and 3:30pm to 6:30, nurse appointments from 8:30am to 1:30pm)

In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them. Staff told us that follow up appointments could be booked more than two weeks in advance if a GP or nurse requested this.

The practice told us they were trying to encourage more patients to book appointments using the online access system and consequently made half of all appointments available for online booking. However, uptake of this system was still relatively low and many appointments which were allocated to online booking were subsequently booked by receptionists for patients telephoning or arriving in person.

We asked when the next urgent appointment was available and were told an appointment was available for the following day. The next available routine appointment could be booked online and was within one week.

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

- 41% of patients were satisfied with the practice's opening hours compared to the national average of 84%.
- 17% of patients said they could get through easily to the surgery by phone (national average 73%).
- 5% patients said they always or almost always see or speak to the GP they prefer (national average 36%).

People told us on the day of the inspection that they were usually able to get appointments when they needed them. We discussed the results of the survey with the practice and were told that the practice was experiencing significant

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

difficulties recruiting GPs and a full time practice manager and this was impacting on patient access. The practice had installed an extra telephone line but had not increased the number of staff available to answer calls. The most senior member of the reception team was undertaking certain practice management duties and this had affected the amount of time they were able to spend fulfilling reception duties but their absence had not been addressed or mitigated by the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns but this was not widely publicised.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The senior GP was the responsible person who handled all complaints in the practice.
- There was no information to help patients understand the complaints system displayed in the practice. We saw that information was available to help patients understand the complaints system on the practice website.

We looked at nine complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Patients received a written response with an apology when appropriate.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision to deliver high quality care and promote good outcomes for patients and we did not see documented values, a mission statement or objectives.

The practice did not have an up to date business plan or risk assessment so business pressures, aims and objectives had not been documented or mitigating actions recorded.

Governance arrangements

Governance arrangements were unclear.The practice had some policies and procedures in place to govern activity. However most of these were out of date and had not been reviewed or were undated so it was difficult to assess whether they had been appropriately reviewed. For example, safeguarding and chaperone policies had not been updated since 2012. The infection control policy had not been reviewed since 2012 and a fire risk assessment review date for 2013 had not been met.

Where policies were available to staff they were in paper form in a file in reception. However not all staff were aware of the policies, for example staff we spoke with who had undertaken chaperoning duties were unfamiliar with the chaperone policy.

Limited attention was given to quality improvement activity such as clinical audits or local benchmarking. There was no evidence of any clinical meetings between the GP and the practice nurse or of any formal discussions to discuss issues such as the implementation of National Institute for Health Care and Clinical Excellence (NICE) guidelines or Quality Outcomes Framework (QOF) performance. QOF achievement rates had reduced from 99.2% in 2012/13 to 96.6% for 2013/14 and 88.6% for 2014/15.

The leadership structure, with the exception of the GP principal was unclear. The practice had three practice managers in three years and had not yet appointed a new practice manager after the most recent departure which was in 2015. An experienced member of the administration team was fulfilling some practice management duties but had not been provided with a job description or received any formal training to support them in this role.

Without a firm leadership structure, it was not clear how effective the structure was in terms of supporting safe care. For example, the GP principal and nurse were joint leads for infection control, however, training for these roles had not taken place or was out of date.

We spoke with two members of staff and they were clear about their own roles and responsibilities. They told us the practice was a good place to work and they felt their views would be listened to and they knew who to go to in the practice with any concerns. However,

we were also told that there were times when there were not enough staff available to cover staff illness or annual leave and this impacted on the level of service provided to patients. Staff told us they regularly worked over and above contracted hours.

The practice had not identified, recorded and managed risks. There were no environmental risk assessments recorded and no evidence of action taken to reduce risk in areas including infection control, legionella, fire safety and general building risks. We did not see evidence of risks being discussed at meetings although staff told us this was done informally when necessary.

Leadership and culture

Before we undertake an inspection, we ask providers to submit certain information including, summaries of complaints and serious adverse events, numbers of staff by role as well as details of training and qualifications, recruitment and training policies and evidence of the quality of care for the six population groups we inspect. The practice had not responded to this request. We asked about this during our inspection and were told that the practice had not properly understood the request and did not have the resources available to engage with or to fulfill the request.

Leaders did not have the necessary capacity to lead effectively. There was a lack of involvement, oversight and leadership from the GP. There was no effective system for managing issues and risks arising from inadequate arrangements for chaperoning, safeguarding, fire safety and infection control. This indicated that quality and safety were not a priority for the leadership.

Significant issues that threatened the delivery of safe and effective care were not identified or adequately managed. Although staff told us that they felt respected, valued and

Are services well-led?

Inadequate

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

supported there was no evidence to suggest they were involved in discussions about how to run or develop the practice, or of being encouraged to identify opportunities to improve the service delivered by the practice. There was no evidence of innovation or service development and minimal evidence of learning and reflective practice.

Staff told us the practice aimed to hold non–clinical staff meetings but these were irregular and were not attended by all members of staff.

The practice had systems in place for knowing about notifiable safety incidents. When there were unexpected or unintended safety incidents, these were recorded but there was no systematic process for ensuring that lessons were learned and changes to working practice implemented or explanations provided to patients.

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

There was an active patient participation group (PPG) at the practice. There was a notice in reception advertising the group. The PPG annual report for 2014/15 indicated that feedback received from the Family and Friends Test and from reviews submitted to NHS Choices were discussed at quarterly meetings of the group but we did not see any evidence to support this. We were told the GP did not attend PPG meetings.

There was no evidence that regular feedback was gathered from staff. Staff we spoke with told us that they discussed concerns when they had staff meetings, which were infrequent. We were told that this feedback was not always acted upon, for example, concerns had been raised about workload. Staff were not engaged in how the practice was run.

We could not find any evidence that there had been any analysis of the results from the national patient survey. The practice had not taken the opportunity to develop an action plan to address the areas the survey had identified as requiring improvement. The PPG annual report for 2014/15 outlined a number of priority areas and referred to actions the practice had taken but it was unclear whether these had brought about any improvement. For instance, the report indicated that patient frustration at poor telephone access was resolved by altering the system so patients would hear an engaged tone rather than enter a queueing system but did not demonstrate that patients would benefit from any improvement to access.

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 do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. The registered person had failed to: • Assess the risk of, prevent, detect and control the spread of infections. • Assess the risks associated with fire. • Carry out a risk assessment to determine if staff who act as chaperones need a DBS check. 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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not do all that was reasonably practicable to assess, monitor and improve the quality and safety of the services provided. They had failed to:

This section is primarily information for the provider

Requirement notices

- Ensure there was an effective system in place for the receipt and distribution of safety alerts to all staff.
- Ensure that there were processes for identifying where improvements in clinical care could be made and monitored (such as two cycle completed clinical audits).
- Take effective and sustainable action in response to patient feedback relating to lack access to the service, difficulties obtaining suitable appointments , involvement in decisions about their care and explanations of tests and treatments.

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 registered person did not do all that was reasonably practicable to ensure that persons employed by the service provider received such appropriate support, training professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. They had failed to: • Ensure that all staff had received training about confidentiality and information governance • Ensure staff are supported with and receive professional development, supervision, training and appraisal to enable them to undertake their role. • Provide appropriate training to staff required to carry out chaperone duties. • Ensure that all staff had received appropriate training on infection prevention and control.

This section is primarily information for the provider

Requirement notices

This was in breach of Regulation 18 (1)(2)(a)(b)(c) 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** Appropriate pre-employment checks were not carried out to ensure the safe and effective recruitment of staff. This was in breach of Regulation 19 (1)(a)(b), (2)(a), (3)(a)(b) and (4)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014