Dr Swaminathan Ravi

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	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 on 1 July 2016 at Dr Swaminathan Ravi at Cope Street Surgery. The practice was placed in special measures due to non-compliance with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 following our previous inspection in November 2015.

During this inspection, we found the practice had made some improvements since our last inspection and most of the issues raised had been rectified. However fresh concerns and breaches of regulations were noted.

The provider is in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment, Regulation 17 Good Governance and Regulation 18 Staffing.

We found the practice to be inadequate in areas relating to safe, effective and well led. The practice was rated as requires improvement for areas related to being responsive and was rated as good at caring for patients.

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

- During this inspection we found the practice had reviewed some of their systems to ensure risks to patients were addressed and managed. For example a fire risk assessment had been completed along with Control of Substances Hazardous to Health (COSHH) and Legionella risk assessments. However we found shortfalls in other areas. For example, the safeguarding policy had been updated but did not contain details of local social services and clinical commissioning team safeguarding contacts.
- 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.

Summary of findings

- 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:

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- To review the findings of the infection prevention and control audit to reflect a true picture of the practice and act in accord with the findings.
- Ensure the guidance from NHS Protect security of prescription forms is implemented and systems established.
- Ensure paper and electronic records are held securely meeting the requirements of the Data Protection Act 1998.
- Ensure that all staff performing chaperone duties have received a disclosure and barring service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- Ensure processes are in place for the safe management of returned or unwanted medicines.
- Ensure patient outcomes are reviewed and recommendations made to contribute to a programme of continuous quality improvement.
- To review the staff appraisal process so that all staff have regular appraisals and performance reviews.

The areas where the provider should make improvement are:

- Ensure a GP lone worker risk assessment is completed. The GP was the sole provider for clinical care and took the lead for everything. There was no risk assessment undertaken for the GP being a lone clinical workernor clear instructions to follow if they were unable to work.

This service was placed in special measures on 30 November 2015. Insufficient improvements have been made such that there remains a rating of inadequate for safe, effective and well led. Therefore we are taking 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 six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

- Not all staff we spoke with were clear about reporting incidents, near misses and concerns. The procedure for dealing with significant events was not embedded and staff did not report near misses and lower risk events.
- Some arrangements were in place to safeguard adults and children from abuse which reflected relevant legislation and local requirements and policies were accessible to all staff. The policies did not contain local social services and clinical commissioning team contact details for further guidance if staff had concerns about a patient's welfare.
- There was a lead member of staff for safeguarding; however staff we spoke with were not sure who lead was.
- Not all staff who acted as chaperones had received a disclosure and barring service (DBS) check. We were shown an email to confirm the DBS service had received DBS applications for administration staff on 29 June 2016.
- Staff had not yet undertaken chaperone training as they were waiting for their DBS checks to be completed. Some staff told us they still performed chaperone duties, other staff told us the practice nurse would chaperone patients if they were on site when a chaperone was needed.
- Processes were in place for safe management of medicines, however we found some shortfalls, and we found a number of medicines prescribed for specific patients in a basket in an unlocked cupboard. One medicine was a sedative, another was anti-epileptic medication.
- There was an infection prevention and control (IPC) protocol in place and staff had received up to date training. However we found that the protocol was not always followed, for example we observed a sharp's box, which was over full, half secured with a needle sticking out. The GP was made aware of these immediately.
- We found expired dressings and equipment that had significantly passed it's expiry date, for example gloves available for use with an expiry date of 2002.

Summary of findings

- During this inspection we found the practice had reviewed some of their systems to ensure risks to patients were addressed and managed.For example a fire risk assessment had been completed along with COSHH and Legionella risk assessments.

Are services effective?

Inadequate

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

- Staff did not always understand the relevant consent and decision making requirements of legislation and guidance, for example when gaining consent from children and young people.
- Data showed that care and treatment was not always delivered in line with recognised professional standards and guidelines. Not all staff could demonstrate how to access policies and guidelines.
- Patient outcomes were hard to identify as little reference was made to audits or quality improvement and there was little evidence that the practice was comparing its performance to others; either locally or nationally.
- There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required. Not all staff had received training relevant to their role. For example,basic life support and chaperone training for reception staff.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care with the exception of the number of patients who said that the GP was good at explaining tests and treatments. This was 75% compared to the CCG average of 86% and the national average of 86%.
- Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- There was no system in place to record patients with caring responsibilities.
- Information for patients about the services available was easy to understand and accessible.

Summary of findings

- We saw staff treated patients with kindness and respect and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.
- Feedback from patients reported that access to the GP and continuity of care was available with urgent appointments available the same day.
- Patients could get information about how to complain in a format they could understand.
- There was limited use of systems to record and report safety concerns, incidents and near misses and no evidence of shared learning with staff.

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.
- There was no clear leadership structure and staff did not feel supported by management.
- The practice did not have clearly defined and embedded systems, processes and practices in place to keep people safe. Whilst there were some practice specific policies and procedures available to staff we found that staff were not always aware of them.
- All staff had received inductions but not all staff had received regular performance reviews, had clear objectives or attended staff meetings and events.
- The practice had sought feedback from patients and had a patient participation group.

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 practice is rated as inadequate for being safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Care and treatment of older people did not always reflect current evidence based practice, and some older people did not have care plans where necessary.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were poor. For example, performance in indicators for hypertension (raised blood pressure) was 74% which is 20% lower than the CCG average and 24% below the national average.
- Home visits were available for patients that could not attend the practice.

People with long term conditions

Inadequate

The practice is rated as inadequate for being safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Performance in the asthma related indicators at 28% was substantially lower than the CCG average of 88% and the national average of 97%.
- Performance for diabetes related indicators at 63% was substantially lower than the CCG average of 84% and the national average of 89%.
- Longer appointments and home visits were not available for the review of patients with long term conditions.
- These patients did not have a personalised care plan.
- Annual reviews were not actively offered to check that patients' health and care needs were being met.

Families, children and young people

Inadequate

The practice is rated as inadequate for being safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The GP could not demonstrate that there was a system in place to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk.
- Staff did not always understand the relevant consent and decision making requirements of legislation and guidance,

Summary of findings

including when providing care and treatment for children and young people. The GP told us that he has never used Gillick competency assessment (a way of assessing whether a child or young person has the capacity to understand information given and make informed decisions).
- The practice's uptake for the cervical screening programme was 88%, which was higher than the CCG average of 83% and the national average of 82%. There was not a policy to offer telephone reminders for patients who did not attend for their cervical screening test and staff we spoke with were unsure how these patients would be followed up.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for being safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered early morning appointments three days a week for patients who found it difficult to attend during normal hours.
- The practice offered online services as well as health promotion and screening that reflects the needs for this age group. These services did not appear to be promoted.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for being safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice held a register of patients living in circumstances that might make them vulnerable including homeless people, travellers and those with a learning disability. However there was no system in place to alert staff of these patients.
- We were told that the practice offered longer appointments for patients with a learning disability although there was no system in place to alert staff of these patients when they requested an appointment.
- The practice worked with other health care professionals in the case management of patients whose circumstances might make them vulnerable.
- Patients whose circumstances might make them vulnerable were advised about how to access various support groups and voluntary organisations only if they requested this information.

Summary of findings

- Staff knew how to recognise signs of abuse in adults and children. Staff were aware of their responsibilities regarding information sharing,

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for being safe, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Of those patients diagnosed with dementia, 52% had received a face to face review of their care in the last 12 months, which is substantially lower than the CCG and national average of 77%.
- Performance for mental health related indicators at 67% was substantially lower than the CCG average of 82% and the national average of 93%.
- The practice had worked with multi-disciplinary teams in the case management of people experiencing poor mental health.
- The practice did not carry out advance care planning for patients living with dementia.
- The practice did not have a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had not received training on how to care for people with mental health needs and assessing capacity to consent to care and treatment.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages. Of the 246 survey forms distributed,103 were returned.This represented 3% of the practice's patient list.

- 99% of patients found it easy to get through to this practice by phone compared to the CCG average of 64% and the national average of 73%.
- 98% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and the national average of 85%.
- 91% of patients described the overall experience of this GP practice as good compared to the CCG average of 83% and the national average of 85%.
- 85% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 77% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 44 CQC comment cards which were all positive about the standard of care received. Comments received included "Excellent service, can always fit you in at short notice" and "Very caring and helpful".

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

Areas for improvement

Dr Swaminathan Ravi

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Dr Swaminathan Ravi

Dr Swaminathan Ravi, known as Cope Street Surgery is situated in the centre of Barnsley.

The practice provides services for 3,032 patients under the terms of the locally agreed NHS General Medical Services contract.

The practice catchment area is classed as within the group of the second most deprived areas in England. The age profile of the practice population is broadly similar to other GP practices in the Barnsley Clinical Commissioning Group (CCG).

There is one full-time male GP, a part time female practice nurse, supported by reception staff and a part time locum business manager.

The practice is open;

Monday 8.00 am to 6.00 pm.

Tuesday and Wednesday 7.30 am to 6.00 pm.

Thursday 7.30 am to 1.00 pm.

Friday 8.00 am to 6.00 pm.

Care UK provides cover on Thursday afternoon and each day between 6.00 pm and 6.30 pm.

Out of hours care can be accessed via the surgery telephone number or by calling the NHS 111 service.

Extended hours surgeries are offered 7.30 am to 8.00 am Tuesday to Thursday.

We inspected Dr Swaminathan Ravi on 30 November 2015 and it was found to be rated overall as inadequate. On the basis of that inspection and the ratings given to the practice, the registered provider was placed into special measures. This was for a period of six months during which time the provider was expected to improve the practice to meet the required regulations and fundamental standards.

Special measures are designed to ensure a timely and co-ordinated response to practices found to be providing inadequate care that gives them support from NHS England and the Clinical Commissioning Group. Practices can choose to get further peer advice and support from the Royal College of General Practitioners. Being placed into special measures represents a decision made by CQC that a practice has to improve within six months to avoid having its registration cancelled.

The issues raised during the inspection on 30 November 2015 were found to be mostly resolved. However fresh concerns were highlighted during this inspection.

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 following six months in special measures. This inspection was planned to follow up whether the registered 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.

Please note 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.

We undertook a comprehensive inspection of Dr Swaminathan Ravi on 30 November 2015. The practice was rated as inadequate overall and for the safe, effective and well-led domains. It required improvement in the responsive domain and was good for caring. In addition, all five population groups were rated as inadequate. Due to the overall inadequate rating, the practice was placed in special measures.

The practice was found to be in breach of five regulations of the Health and Care Social Act 2008 Regulations 2014.

Requirement notices were set for the regulations relating to good governance and safe care and treatment.

How we carried out this inspection

Before visiting, we reviewed information we hold about the practice and asked Barnsley CCG and NHS England to share what they knew. We also reviewed the action plan the provider had submitted in March 2016 to address the requirement notices set.

We carried out an announced visit on 1 July 2016.

During our visit we spoke with the GP, the practice nurse, two reception staff members and a member of staff from the commissioning support unit.

We also spoke with six patients who used the service and reviewed 44 CQC patient comment cards where patients and members of the public shared their views and experiences of the service. We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area.

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

When we visited the practice in November 2015 systems, processes and practices were not reliable to keep people safe. Not all staff we spoke with were clear about reporting incidents, near misses and concerns. They were unsure about which events to report. The procedure for dealing with significant events was not embedded and staff did not capture near misses and lower risk events.

There were no documented procedures or examples to show how learning from peer reviews, complaints, significant events or safety alerts were shared within the staff team to support improvement.

During this inspection, we were shown the system the practice had introduced for reporting and recording significant events. The significant event procedure had been updated in April 2016. Staff told us they were unsure of what was meant by a significant event and there was a recording form available on the practice's computer system which they had not yet used.

We reviewed one significant event record from April 2016. The feedback originally came into the practice as a complaint from a patient. The incident record contained the investigation undertaken and reported how to avoid the situation happening again. We were told the meeting where this was discussed was not documented. We noted a monthly practice newsletter was circulated to staff to update them on the changes to policy and procedures.

Overview of safety systems and processes

Previously we found arrangements to safeguard adults and children from abuse were not adequate in relation to staff training, clarity of lead roles and identification of patients considered to be at risk. Arrangements to provide chaperones for patients were in place but staff had not received training and appropriate disclosure and barring (DBS) checks. There were no formal induction processes for new or locum staff.

The practice had reviewed some systems, processes and practices in place to keep people safe and we found shortfalls in other areas.

During this inspection we observed some arrangements were in place to safeguard adults and children from abuse which reflected relevant legislation and local requirements and policies were accessible to all staff. The policies did not contain local social services and clinical commissioning team contact details for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff we spoke with were not sure who the safeguarding lead was. We were told staff would attend safeguarding meetings when possible and reports would be provided, where necessary, for other agencies. Staff we spoke with demonstrated they understood their responsibilities and all had received training relevant to their role since our last visit. We asked to see the system to highlight those patients whose circumstances may make them vulnerable on the practice's electronic records. This included information to make staff aware of any relevant issues when patient's contacted the practice or attended appointments. We were told the practice had no patients currently registered with them who met this criteria. We were shown minutes of one meeting with the health visitors, community matrons and social care teams to discuss safeguarding concerns.

A notice in the waiting room, advised patients staff would act as chaperones, if required. Not all staff who acted as chaperones had received a disclosure and barring service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We were shown an email to confirm the DBS service had received DBS applications for administration staff on 30 June 2016. Staff had not yet undertaken chaperone training as they were waiting for their DBS checks to be completed. Some staff told us they still performed chaperone duties, other staff told us the practice nurse would chaperone patients if they were on site when a chaperone was needed. The practice nurse worked 16 hours per week.

We found during our visit on 30 November 2015 that systems, processes and practices to manage medicines were not always reliable or appropriate to keep people safe. There were some shortfalls in the processes to ensure the safe storage of vaccines, emergency drugs and checking of emergency equipment. During this inspection we checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place and implemented to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. However, we observed a sharp's box to be over filled and half secured with a needle sticking out. We observed a large box of water for injections in the vaccine fridge which were prescribed for a specific patient. We observed insulin needles, saline and dressings stored on the premises prescribed for specific patients.

Expired and unwanted medicines were not disposed of in line with waste regulations. For example, we found a number of medicines prescribed for specific patients in a basket in an unlocked cupboard. One medicine was a sedative, another was anti-epileptic medication. We made the GP aware of this and we were told they would be disposed of correctly.

We observed gloves available for use in one treatment room that had significantly passed their expiry date of 2002.

We found boxes of blank prescription forms kept in an unlocked cupboard in the waiting room. We were told they were not tracked through the practice to comply with NHS Protect prescription security guidance. We were told by the GP on the day of the inspection that these would be secured immediately.

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. Patient Group Directions (PGDs) had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. We saw evidence the practice nurse had undertaken recent appropriate training and had been assessed as competent to administer the medicines referred to within the PGDs.

We were told there had been no new recruits to the practice since our last visit. We reviewed two recruitment files for existing staff and found appropriate recruitment checks had been undertaken since employment. For example, proof of identification and employment history.

We were shown an email to confirm receipt of appropriate checks through the Disclosure and Barring Service for administration staff dated 30 June 2016, however the results of these checks were not yet available.

Monitoring risks to patients

We previously found risks to patients were not assessed or well managed. The practice did not maintain a risk log or records to show risks were discussed at meetings. Regular fire drills were not performed and there was no evidence that regular checks of alarm points or emergency lighting was carried out. The practice did not have a lead member of staff for fire safety. There was no formal risk assessments for the control of substances hazardous to health or legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). A member of staff undertaking chronic disease management reviews had no formal training in any of the chronic disease areas.

During this inspection we found the practice had reviewed some of their systems to ensure risks to patients were addressed and 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 to staff in the practice handbook dated April 2016 and there was a Health and Safety poster in the reception office which identified local health and safety representatives. Most of the electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly, with the exception of the baby scales which were last checked and calibrated in March 2015 and a 24 hour BP monitor which was last checked and calibrated in February 2015.

The practice had also introduced a control of substances hazardous to health risk assessment. We were shown a legionella risk assessment which was completed in January 2016. We were told cleaning staff ran the taps regularly to reduce the risks of legionella and observed the documented records.

The practice nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol in place and staff had received up to date training. We asked to see IPC self-audit completed on 12 January 2016. The documented audit responses did not reflect what we observed. We also noted not all of the actions identified had been completed. For example there were still plugs in

sinks, cleaning products were stored in unlocked cupboards and there was no hand soap in some rooms and no paper towels in others. Staff told us they used kitchen roll to dry their hands on as they had run out of hand towels the month before.

We observed shower curtains in use as privacy screens in all clinical rooms. We noted they were not fire retardant and we were told they were soaked in a Milton bath monthly. We observed a cleaning schedule which instructed cleaning of the door handles daily. We noted door handles were heavily marked and no evidence they had been cleaned recently. The practice did not keep a record of cleaning.

Since our last inspection the locum nurse practitioner no longer worked at the practice. We were told GP locums were used as required. The locum GP pack was incomplete and not updated since 2012. We were told that the locum business manager was on leave until the end of August 2016. This raised concern as the GP was the sole provider for clinical care and took the lead for everything. There was no risk assessment undertaken for the GP being a lone clinical worker. We were shown contact details of locum GP agencies. We noted there was no contingency if the GP was unavailable and the GP told us they would arrange for another GP to cover their work if they took time off. The GP told us they had not had any period of absence for a number of years. Reception staff told us they covered each other's annual leave.

Arrangements to deal with emergencies and major incidents

During our previous inspection the risks associated with anticipated emergency situations were not fully recognised. Fire alarms were not routinely tested. We found out of date equipment in treatment rooms and emergency medicines were prescribed in the name of individual patients. The defibrillator was still in its original packaging from 2014 and not prepared for use. There was no evidence oxygen cylinders were checked and only adult masks were kept.

During this inspection we noted three administrative staff were still to complete annual basic life support training. We were told this was due to the sessions being held on the days they did not work.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. Emergency medicines were correctly procured and easily accessible to staff in a secure area of the practice and all staff knew of their location. However we observed that staff were not up to date with basic life support training.

We were shown a business continuity plan which had been produced and implemented in April 2016 to deal with a range of emergencies that may impact on the daily operation of the practice. The document was brief and did not rate each risk and provide mitigating actions for power failure, adverse weather, unplanned sickness and access to the building. The document did not contain relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed or staff contact telephone numbers.

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

The practice had carried out a fire risk assessment in partnership with the local fire officer in December 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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. The GP used templates based on guidelines; however he relied on the CCG to let him know when guidance was updated.

The practice nurse used NICE guidance on the computer system. The GP was unsure how to access this.

There was limited recognition of the benefit of an appraisal process for staff and little support for additional training that was required.

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 66% of the total number of points available which is 23% below the CCG average and 29% below the national average. Exception reporting was 5% (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 was 3% below the CCG average and 4% below the national average.

Data from 2014/15 showed:

- Performance in the asthma related indicators at 28% was substantially lower than the CCG average of 88% and the national average of 97%.
- Performance for diabetes related indicators at 63% was substantially lower than the CCG average of 84% and the national average of 89%.
- Performance for mental health related indicators at 67% was substantially lower than the CCG average of 82% and the national average of 93%.

We were shown three clinical audits that had been completed in the last two years, with support from the medicines management team at the CCG. One of these was a completed audit, however it was too early to assess whether improvements were made.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

The practice could now demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, however limited time was given to support this.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.

The learning needs of some staff were identified through appraisalsand meetings, however not all staff had received an appraisal within the last 12 months and not all staff attended meetings. . Staff had access to appropriate training to meet their learning needs and to cover the scope of their work, however not all training had been completed. Not all staff had received an appraisal within the last 12 months. The nurse had not received a clinical appraisal or received support for revalidation. This was noted in the previous inspection but still not undertaken.

Staff received training that included: safeguarding, fire safety awareness, and information governance. However not all staff had attended training on basic life support. We were told this was because sessions were held on days they don't work. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

Inadequate

Are services effective?

(for example, treatment is effective)

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. However the GP was unsure how to access policies and procedures on the computer.

We found that patients with the most complex needs, who were at risk of admission to hospital, did not always have a documented care plan or review of their care needs.

Information such as NHS patient information leaflets were available.

The practice shared relevant information with other services in a timely way, for example when referring people to other services.

Staff told us that they worked together and with other health and social care services to understand and meet the range and complexity of people's needs. This included when people moved between services, including when they were referred, or after they were discharged from hospital. However there was no system in place to monitor and review unplanned admissions and re-admissions of patients.

There was no system in place to alert staff when patients were at risk of a long term condition, or those at risk of unplanned admission to hospital.

We saw evidence that multidisciplinary team meetings took place. These had only just been recommenced and required time to become embedded into practice.

Consent to care and treatment

Staff had not always sought patients' consent to care and treatment in line with legislation and guidance. Staff did not always understand the relevant consent and decision making requirements of legislation and guidance, including when providing care and treatment for children and young people. The GP told us that he had never used a Gillick competency assessment.

No evidence of training in the Mental Capacity Act was seen.

The process for seeking consent was not monitored through audit of patient records..

Supporting patients to live healthier lives

The practice had not identified all patients who may be in need of extra support.

There was no system to identify those at risk of developing a long term condition and those requiring advice on their diet, smoking and alcohol cessation.

We were told that there was a record of patients with palliative care needs, however the staff we spoke with did not know how to identify these patients. On the day of the inspection the GP did not know how to access this record.

The practice's uptake for the cervical screening programme was 88%, which was higher than the CCG average of 83% and the national average of 82%. There was not a policy to offer telephone reminders for patients who did not attend for their cervical screening test and staff we spoke with were unsure how these patients would be followed up.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 97% to 100% and five year olds from 86% to 100%.

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

Requires improvement

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 44 CQC patients 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 six patients. They also 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 mostly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them compared to the clinical CCG average of 88% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 98% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

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. Feedback from the CQC patient comment cards we received was also positive and aligned with these views.

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. Results were in line with local and national averages. For example:

- 75% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

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

Staff told us that interpreter 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

Requires improvement

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which advised patients how to access a number of support groups and organisations.

The practice computer system did not alert staff if a patient was also a carer. Staff told us they would document that a person had caring responsibilities if it was disclosed on registration at the practice but these were not kept on a register.

Staff told us if families had experienced bereavement, they would offer support if they contacted the practice.

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 by using its own patient surveys.

The practice offered early appointments on Tuesday, Wednesday and Thursday mornings for working patients who could not attend during normal opening hours.

Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

Same day appointments were available for children and those patients with medical problems that require same day consultation.

There were longer appointments available for patients with a learning disability, however there was no alert set up on the patient record to alert staff of these patients.

Patients were able to receive travel vaccinations available on the NHS.

There were disabled facilities, a hearing loop and interpretor services available.

Access to the service

The practice was open:

Monday: 8.00 am to 6.00 pm.

Tuesday: 7.30 am to 6.00 pm.

Wednesday: 7.30 am to 6.00 pm.

Thursday: 7.30 am to 1.00 pm.

Friday: 8.00 am to 6.00 pm.

Extended hours appointments were offered between 7.30 am and 8.00 am Tuesday to Thursday.

Care UK provided cover on Thursday afternoon and each day between 6.00 pm and 6.30 pm.

Out of hours care could be accessed via the surgery telephone number or by calling the NHS111 service.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

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

- 94% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and the national average of 78%.
- 99% of patients said they could get through easily to the practice by phone compared to the CCG average of 64% and the national average of 73%.

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

The practice had a system in place to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention. When patients or carers requested emergency appointments or home visits, reception staff told us they would put calls directly through to the GP or take a verbal message and the GP would telephone the patient or carer back to assess the need for a visit.

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

Listening and learning from concerns and complaints

There was limited use of systems to record and report safety concerns, incidents and near misses. There had been one recorded complaint in the last 12 months. We noted this was satisfactorily handled and dealt with in a timely way. Most complaints were handled verbally.

Most complaints were handled verbally by the reception staff, not documented or discussed as a team.

There was a designated responsible person who handled all complaints in the practice; however staff we spoke with were unsure who this was. Staff told us that the reception staff would try to deal with complaints verbally. If the reception staff could not deal with the complaint they told us they would ask the GP to speak with the person making the complaint. This process was verbal and only one complaint was documented in the last 12 months.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information in the form of a poster was available to advise patients how to make a complaint and posters were displayed in the waiting rooms.

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

When we inspected the practice in November 2015 staff did not share a clear vision although they worked hard to maintain patient satisfaction. The GP was supported by a locum business manager who worked 7.5 hours per week whom staff referred to as the practice manager. We were told this role was to support with administration duties.

During this inspection we were told the practice had an improvement plan to focus on improvements needed relating to the regulatory breaches and being in special measures.

The GP had not documented longer term actions in a business plan.

Staff spoke enthusiastically about working at the practice and their role was to provide the best care to patients. We asked if the practice had developed an overall vision or practice values that staff had taken time out to contribute to and staff told us this had not yet happened.

Governance arrangements

When we inspected the practice in November 2015 we found the practice governance framework to support the delivery of good quality care required improvement. The practice did not have clearly defined and embedded systems, processes and practices in place to keep people safe. Whilst there were some practice specific policies and procedures available to staff we found that staff were not always aware of them, for example, the whistleblowing policy.

During this inspection we were shown the practice staff handbook which contained a number of recently renewed/ updated policies and procedures (April 2016) in place to govern activity. These were available to staff in a paper file and on the computer in a shared drive. We looked at five of these policies and procedures which were not practice specific, did not contain relevant local contact details and there was no evidence that they had been reviewed by staff in a meeting or on the individual policies. For example the child safeguarding policy did not contain the local social services and CCG contacts.

The practice staff handbook included human resource policy and procedures. Staff told us they were aware of the folder and would refer to it if they needed guidance.

We were shown a monthly newsletter circulated to staff which contained updates to policy and procedures and asked staff for feedback. Staff told us they had not yet provided feedback.

During the previous inspection the GP demonstrated an understanding of the performance of the practice and had been working towards improvements in prescribing with support from the CCG and concentrating on patient experience. We were told during this inspection the business manager took the lead for the performance of the practice and the GP was unsure of the QOF outcomes achieved for 2015/16.

During our previous visit we noted records were not adequately maintained. For example recruitment records were not well organised, records of emergency equipment and vaccine fridge temperature checks were not kept.

During this inspection we observed the emergency equipment and vaccine fridge temperature recordings were completed and documented. Staff files had been organised to contain relevant information. However we did observe patient record management was not always sufficient. We observed patient notes were stored in unlocked cabinets in the patient waiting area with easily recognisable patient names on the cabinet drawers. These were accessible to the general public. We asked reception staff if there were keys for these cabinets. During the visit we were told the key was found and the cabinets had been locked.

Blank prescriptions were kept in unlocked cupboards in the reception area we were told they were not tracked through the practice. During the inspection we were told by the GP that these would be secured.

During our previous inspection we found an unlocked door in the waiting room led to a dark cellar. We observed during this visit the door had been secured and the cellar was inaccessible to patients.

We were told the practice held quarterly meetings where governance issues were discussed. We were told actions and minutes from the meetings were not kept. Staff who did not attend the meeting were updated via the monthly practice newsletter.

Are services well-led?

Inadequate

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

There was no clinical supervision and support for revalidation for for nursing staff.

Leadership, openness and transparency

When we inspected the practice in November 2015 during our discussions with staff there was some confusion at times as to roles and responsibilities. The practice did not have a clear leadership structure and some staff were unclear as to who took the lead roles. For example, not all staff knew who took the lead for infection prevention and control. During this inspection staff were still unclear of who took the lead for some areas. The GP partner was the lead for safeguarding, however, not all staff we spoke with knew this. We spoke with two members of staff and they were clear about their own roles and responsibilities.

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

The practice encouraged and valued feedback from patients, the public and staff. It reviewed the way it sought patients' feedback and engaged patients in the delivery of the service.

They had started to gather feedback from patients through the patient participation group (PPG). Most members of the PPG were new to the group and they had met twice. They planned to meet regularly and had scheduled meetings for the rest of the year. They had suggested improvements to the practice management team. For example, the 'you said, we did' board in reception had been implemented to provide feedback to patients through the comments and compliments process.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 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 enable staff to carry out the duties they were employed to perform. This is because: They failed to provide staff with regular appraisals or review of performance. This was in breach of regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to provide care and treatment in a safe way for service users. This was because: 12 (1) (2) (b) Staff did not have a good understanding of incident reporting processes. We asked staff how they would raise incidents and near misses. Staff told us they were unsure of the procedure and what an incident could be. We noted only one incident had been reported in the last 12 months which was also a complaint to the practice. 12 (1) (2) (c) We asked to see DBS checks for staff that chaperoned patients. We noted applications were confirmed as received by the DBS service on 29 June 2016. Staff told us they still chaperoned patients. We saw in the staff newsletter dated April and May 2016 a note stating administration staff should no longer chaperone patients. 12 (1) (2) (e) The practice did not ensure the equipment used for providing care or treatment to a service user is safe for such use and is used in a safe way. We observed in a treatment room: • Two bottles of sterilising fluid left on the work surface in an unattended treatment room. • The blood pressure monitor contained a sticker stating it was last calibrated on 31 March 2015. The baby scales contained a sticker to record they were last calibrated in February 2015

This section is primarily information for the provider

Enforcement actions

We observed several expired, dirty active inhalers and supplies in two treatment rooms, swabs, urinalysis sticks, suture packs, dressing packs which appeared to be in use. We observed a very dirty box of tongue depressors which appeared to be in use.

A sharp box, over full, half secured with a needle sticking out in one room.

We observed the computer plugged into the electricity supply was located next to the sink in the phlebotomy room.

12 (1) (2) (g)

Expired and unwanted medicines were not disposed of in line with waste regulations. For example, we found a number of medicines prescribed for specific patients in a basket in an unlocked cupboard.One medicine was a sedative, another was anti-epileptic medication.

Water for injection in the vaccine fridge was prescribed for a specific patient and novofine needles. We observed insulin needles and water for injections stored on the premises prescribed for specific patients.

12 (1) (2) (h)

The practice did not adequately assess the risk of preventing, detecting and controlling the spread of infection.

We asked to see the IPC audit completed on 12 January 2016. Not all of the actions identified had been completed. For example there were still plugs in sinks, cleaning products were stored in unlocked cupboards and there was no hand soap in some rooms and no paper towels in others. Staff told us they used kitchen roll to dry their hands on as they had run out of hand towels a month before.

We observed shower curtains in use as privacy screens in all clinical rooms. We noted they were not fire retardant and we were told they were soaked in a Milton bath monthly.

We observed a cleaning schedule which recorded cleaning of the door handles daily. We noted door handles were heavily marked and no evidence they had been cleaned recently.

The practice did not keep a record of areas cleaned.

This section is primarily information for the provider

Enforcement actions

The baby changing mat and baby scales were heavily marked in the treatment room and there was no black bag pedal bin in one treatment room.

This was in breach of regulation 12 (1)(2)(a) (b) (c) (e) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not assess, monitor and improve the quality and safety of the services provided. This was because: 17 (1) (2) (a) A comprehensive understanding of the clinical performance of the practice was not maintained. We asked to see the QOF outcomes for 2015/16 and we were told the business manager took care of this. Overall patient outcomes were not reviewed as part of the practices clinical performance monitoring. 17 (1) (2) (c) Record management was not always sufficient. We did observe some paper patient records stored in a basket in an unlocked room. Patient records were stored in unlocked cabinets in the reception area We asked reception staff if there was a key. During the visit we were told the key was found and the cabinet was locked. We observed further patient record cabinets in an unlocked room upstairs. We noted easily recognisable patient names on the cabinet draws. 17 (1) (2) (d) i and ii The practice did not maintain policies and procedures for staff to refer to to deliver the regulated activities.

This section is primarily information for the provider

Enforcement actions

Reception staff were unsure who the safeguarding lead was. The child safeguarding policy and vulnerable adults policy had been updated as part of staff practice handbook in April 2016. Neither policy was specific to the practice and contained details of the social services and CCG leads.

The business continuity plan had been updated but did not contain any details of utility companies or staff. We asked what the procedure was if the GP was absent and we were told they were never off and locums could be sourced at short notice. We asked to see a GP lone worker risk assessment and were told the practice did not have one.

The locum pack was dated 2012 and had not been updated. Policy and procedures were missing from the pack.

Blank prescriptions were not securely stored and not tracked through the practice.

This was in breach of regulation 17 (1)(2)(a)(c) (d i and ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.