Dr DC Patel and Partners

Quality Report

Broadway 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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr D C Patel and Partners on 21 September 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 identified to address concerns with infection control practice had not been taken.
- There was not a systematic approach to assessing and managing risks. For example, a fire risk assessment was not available.
- While we saw that significant events were analysed and actions identified to mitigate the possibility of the events being repeated, these actions were not consistently implemented.
- The governance arrangements within the practice were insufficient. Policies were not easily accessible to staff and not all were detailed enough to adequately describe the activity to which they related.
- There was a lack of understanding around what training was required for staff, including safeguarding training.
- Several staff had not had an appraisal to identify training needs and manage performance, for example the practice could not evidence during the visit that a health care assistant had been appraised in the last three years.
- The practice carried out clinical audit which demonstrated quality improvement.
- Patients were generally positive about their interactions with staff and said they were treated with compassion and dignity.

Summary of findings

- We saw that complaints were dealt with in a timely manner and an appropriate apology was offered when required.

The areas where the provider must make improvements are:

- Introduce thorough processes to ensure that learning outcomes identified following significant events, incidents and near misses are acted upon.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Implement governance arrangements including systems for assessing and monitoring risks.
- Provide staff with policies and guidance to carry out their roles in a safe and effective manner and which are reflective of the requirements of the practice.
- Ensure staff training is undertaken and appropriately managed to ensure all staff have completed training and have the skills and qualifications to carry out their roles.

The areas where the provider should make improvement are:

- Undertake activity to reinstate and engage with the Patient Participation Group.

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated effectively and so learning opportunities were not maximised. Actions identified following investigations were not always implemented in order to mitigate the possibility of the incident being repeated.
- Patients were at risk of harm because systems and processes were not comprehensively embedded and we were not assured they were sufficient to keep them safe.
- The practice did not have access to a fire risk assessment. A legionella risk assessment had not been completed.
- Clinical staff were administering vaccines without appropriate patient specific directions being in place to ensure this was being done in line with legislation.
- Patient group directions (PGDs) were used to allow nursing staff to administer medicines. However, these were not appropriately signed to demonstrate authorisation and one of the PGDs we reviewed had expired.
- There was a lack of awareness of the level of training required around safeguarding children and vulnerable adults and this resulted in gaps in required staff training in this area.
- Governance around infection prevention and control (IPC) was inadequate. IPC policies available to staff were not comprehensive and staff had not received up to date training. An IPC audit had not been completed in over 12 months. The action plan produced following the last audit completed had not been implemented.

Are services effective?

Requires improvement

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

- Data showed patient outcomes were low compared to the national average for diabetic care.
- The practice assessed patient needs and delivered care in line with national guidelines.
- There was evidence that audit was driving improvement in patient outcomes.

Summary of findings

- Multidisciplinary working was taking place, with meetings held on a monthly basis.
- Practice documentation indicated that 13 staff had not received an appraisal in the previous 12 months.
- The practice did not provide comprehensive evidence demonstrating clinical staff were up to date with role-specific training, for example in the management of long term conditions and administering immunisations and vaccinations.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice had recently started offering specialist diabetes services as well as anticoagulation monitoring for patients at risk of stroke.
- Patients said they generally found it easy to make an appointment with a GP and urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, although not all reception staff were aware of the literature to give patients should they wish to make a complaint.
- Evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff formally at the practice's annual complaints review meeting.

Summary of findings

Are services well-led?

Inadequate

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

- The governance arrangements within the practice were insufficient to ensure safe and effective care was delivered.
- There were a number of policies and procedure in place, but these were not well managed nor always readily available to staff. Several of these documents were duplicated and it was not always clear which was the most up to date.
- A number of the policies lacked sufficient detail to appropriately govern the activity they related to.
- Arrangements for identifying, recording and managing risks were inadequate. Sufficient documentation had not been maintained by the practice for us to be assured that risks were being appropriately managed; for example fire risk assessment and gas and electrical installation safety certificates were not available.
- There was no evidence available to demonstrate staff had access to regular appraisals and performance reviews.
- There had been limited recent engagement with patients to seek their feedback and engage them in the delivery of the service.
- The management of staff training was insufficient to ensure they had undertaken all that was required.
- The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff were aware of the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice held multidisciplinary meetings on a monthly basis where the needs of patients nearing the end of life were discussed to ensure they were being met appropriately.

People with long term conditions

Inadequate

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

- QOF results related to long term conditions such as diabetes, asthma and COPD were generally lower than local and national averages.

However:

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

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

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 75%, which was below the CCG and the national averages of 81%. The practice attempted to offer screening to patients opportunistically to improve uptake.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Inadequate

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Extended hours appointments were available on a Saturday morning to facilitate access for those patients who could not attend during normal working hours.

People whose circumstances may make them vulnerable

Inadequate

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

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

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Although appropriate levels of safeguarding training had not been completed by all staff, we saw that they knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate 

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

- Performance for mental health related indicators was either below or in line with the local and national averages.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above national averages. A total of 221 survey forms were distributed and 105 were returned. This represented a response rate of 47.5% and was 1.1% of the practice's patient list.

- 85% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 92% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 87% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 89% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 45 comment cards, 42 of which were positive about the standard of care received. Comments indicated patients generally felt listened to and received a good service. Some of the cards singled out individual clinicians to praise their care. As well as making positive comments about the practice, 10 of the cards expressed some concerns. These concerns were generally focussed around the time patients had to wait for an appointment. Three of the cards were more negative about the service received, with concerns again being raised around waiting times for appointments and the manner of some staff.

We spoke with one patient during the inspection. This patient said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Introduce thorough processes to ensure that learning outcomes identified following significant events, incidents and near misses are acted upon.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Implement governance arrangements including systems for assessing and monitoring risks.
- Provide staff with policies and guidance to carry out their roles in a safe and effective manner and which are reflective of the requirements of the practice.
- Ensure staff training is undertaken and appropriately managed to ensure all staff have completed training and have the skills and qualifications to carry out their roles.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Undertake activity to reinstate and engage with the Patient Participation Group.

Dr DC Patel and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Dr DC Patel and Partners

The provider Dr D C Patel and Partners currently has two registered locations; Broadway Surgery and Ingol Health Centre. This inspection visit was at Broadway Surgery only. The practice delivers primary medical services to a patient population of approximately 9200 patients under a General Medical Services (GMS) contract with NHS England. The provider holds one single contract with NHS England and the two surgeries share one patient list, with patients able to access services at either site. As such, data presented in this report relates to the whole patient list, with the data aggregated across the two sites.

Broadway Surgery occupies a converted residential property in the Fulwood area of Preston, and is part of the NHS Greater Preston Clinical Commissioning Group (CCG). There is a car park for patients. The building is accessible by a ramp at the entrance and there is a lift to facilitate access to the first floor for patients experiencing mobility difficulties.

The life expectancy of the practice population is in line with the local average and slightly below the national average (82 years for females, compared to the local average of 82 and national average of 83 years, 78 years for males, compared to the local average of 78 and national average of 79 years).

The practice's patient population has a slightly higher proportion of older people than the local averages, for example 20.4% are over the age of 65 (CCG average being 16.2% and national average 17.1%), 10.6% are over the age of 75 (CCG average 7.4%, national average 7.8%) and 2.9% are older than 85 (CCG average 2.1%, national average 2.3%). The proportion of the practice's patients with a long standing health condition is 53%, which is in line with the local and national averages of 54%.

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

The practice is staffed by six GP partners (two female and four male) and one salaried female GP. Other clinical staff consist of five practice nurses and two health care assistants. Clinical staff are supported by a practice manager, assistant practice manager, a site manager for each location and a team of reception and administration staff. The practice also facilitates the training of new GPs.

The practice is open between 8am and 6.30pm Monday to Friday, with surgeries offered between 9am and 11.30 each morning and 3.30pm until 5pm each afternoon. Extended hours appointments are available on Saturday mornings between 8.30am and 11.30am at Broadway Surgery.

Outside normal surgery hours, patients are advised to contact the out of hour's service by dialling 111, offered locally by the provider Preston Primary Care.

Why we carried out this inspection

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

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 September 2016. During our visit we:

- Spoke with a range of staff including GPs, deputy practice manager, two of the practice nurses as well as reception and administration staff and spoke with patients who used the service.
- Observed how staff interacted with patients.
- 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

There was a system in place for reporting and recording significant events, however it was not always effective.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. We saw that there was more than one form available and staff were not consistent about which form would be used. However, we were told that this form was not completed at the time of the incident, but instead when the incident was discussed with the GPs.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We saw that the practice had documented five significant events in the previous 12 months. However, when we reviewed safety records, incident reports, patient safety alerts and minutes of meetings, we saw that these were not handled consistently. While we found that the events were discussed, the documentation maintained around these discussions did not always specify who was present. Actions were identified in order to mitigate the possibility of the incident being repeated. However, in two of the cases the practice was unable to provide evidence during the visit that these actions had been carried out. For example, following an event around a home visit request that occurred in May 2016, the practice had identified the need to review its procedure around home visit criteria. This procedure was displayed in the reception area, but was dated as last reviewed in February 2016. Following another incident around the diagnosis of clostridium difficile (a bacterial infection that affects the bowel) that occurred in November 2015, the practice had identified the need to produce a leaflet for patients informing them how to provide a stool sample. There was no evidence available that this had been done, and clinical staff we spoke to during the inspection were unable to locate the leaflet. The practice provided the inspection team with a copy following the visit.

We saw some evidence that lessons were shared to improve safety in the practice on one occasion; following a significant event audit (SEA) around end of life care, the practice's management of care offered when patients were approaching the end of life was discussed at a team meeting, and we saw minutes confirming this. However, the practice was unable to supply evidence that the outcome of the other four SEAs identified in the last year was formally shared with the broader team. Two of the three reception staff we spoke to were unaware of the recent event around home visit requests.

Overview of safety systems and processes

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

- Arrangements in place to safeguard children and vulnerable adults from abuse were not comprehensive. Policies were accessible to all staff, although staff had some difficulty locating them when asked. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. While staff demonstrated they understood their responsibilities around safeguarding concerns, the practice was unable to demonstrate all had received training on safeguarding children and vulnerable adults relevant to their role. There was a lack of understanding about the training requirements around safeguarding. On the day of inspection no evidence that any clinicians or non-clinical staff had completed accredited safeguarding training to an appropriate level was available. Following the inspection, the lead GP for safeguarding was able to provide evidence that he was trained to safeguarding children level three, and had also undertaken safeguarding adults training. The practice also subsequently provided evidence that two of the other GPs had attended appropriate safeguarding children training at level three. For three of the other GPs, the practice informed us they had provided evidence of training completed around safeguarding. However, these certificates related to training completed on the Mental Capacity Act and Deprivation of Liberty Safeguards. Other staff in the practice had attended an internal training session around

safeguarding provided by the GP safeguarding lead, and two of the nurses had attended a safeguarding conference event locally. This was not training that demonstrated specified levels had been attained.

- A notice in the corridor advised patients that chaperones were available if required. Staff told us that all non-clinical staff had received training for the role. However, there was some confusion amongst the staff regarding which non-clinical staff members were nominated to carry out this duty. Evidence that the four nominated non-clinical staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check, or had been risk assessed for the role was not available during the inspection (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead. There was an infection control protocol in place as well as a needle stick injury policy, although the infection prevention and control (IPC) lead experienced some difficulty in locating these. These documents were both dated as requiring review in January 2016 but reviews had not been completed. The infection control policy document made no reference to cleaning procedures for clinical equipment, did not name the lead staff member who had responsibility for IPC in the practice nor did it acknowledge the need for regular IPC audits to be completed. Staff had not received up to date training; the IPC policy stated staff should receive annual training around infection control. The IPC lead had last attended training on the topic in February 2015. The most recent infection control audit was undertaken in June 2015 and while we saw that this had resulted in an action plan to resolve issues raised, there was no evidence that these actions had been completed. We also noted that a carpeted consultation room upstairs used for clinical procedures, contained an undated, unsigned sharps bin. This room was not included in the IPC audit. The GPs told us that this room was used as a library at the time the audit was completed. However, no updated audit had been carried out given the change in use of the room.
- There were gaps in the arrangements for managing medicines, including emergency medicines and vaccines, (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We noted that there was some risk around the process of a patient's medication being updated following discharge from hospital. These medication updates were processed on the patient's record by administrative staff and sent to the GP to authorise. There was no failsafe system in place to ensure this task was actioned by the GP. We saw that the GPs carried out a monthly audit of a sample of these patients to monitor that authorisation requests were being actioned appropriately. Following the inspection the practice clarified this process to the inspection team in order to describe how risks were mitigated. However, the failsafe outlined was not described in the practice's documented procedure in place to govern this activity. 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. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation, however, the documents available to staff were not signed by the GPs or nurses to demonstrate appropriate authorisation was in place. We saw that the PGD for the shingles vaccine had expired on 31 August 2016. Staff told us that the Health Care Assistants (HCAs) administered vaccines. On the day of the visit, the practice nurses informed us that the HCAs administered vaccines against Patient Specific Directions (PSDs), but these could not be located for the inspection team to view. It was later confirmed by the practice that PSDs were not in place.
- We reviewed six personnel files and found appropriate recruitment checks had not consistently been undertaken prior to employment. For example, there was no evidence that references had been obtained for a member of staff recruited in March 2016. No evidence was present in any of the files for permanent staff that appropriate proof of identification had been sought and documented prior to commencing work. The appropriate checks through the Disclosure and Barring Service were not always evidenced. For example we reviewed one file for an HCA which contained no evidence that a DBS check had been completed. Two other files for non-clinical staff contained no evidence of DBS checks having been completed, and no risk

assessment documented to justify the decision for such checks not being completed. One of the files we reviewed was for a locum GP. Evidence of indemnity insurance contained in this file indicated that the policy had expired on 31 October 2015. Following the inspection the practice clarified that DBS applications for the HCAs had been submitted prior to the visit, and subsequently provided evidence that one of these certificates had been issued two days before the inspection, with the second issued a week afterwards.

Monitoring risks to patients

Risks to patients were not appropriately assessed nor managed.

- There were insufficient procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety poster in the administration office which identified local health and safety representatives. However, the practice did not have up to date fire risk assessments in place. Concern was raised further following the inspection when the practice submitted two letters as evidence of a fire risk assessment being completed. These documents did not include a risk assessment, but instead were letters that confirmed a fire risk assessment had been completed in 2006. They also made reference to subsequent risk assessments that had been completed by external agencies, where risks had been identified and the practice was disputing the risks. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. However, we noted that the practice's vaccine fridge had not been calibrated along with the other clinical equipment in June 2016. The cleaning company contracted by the practice maintained risk assessments around control of substances hazardous to health. While the practice had tested the water supply in the premises for legionella in April 2016 (legionella is a term for a particular bacterium which can contaminate water systems in buildings), we did not see evidence that a risk assessment had been completed to identify if any form of control regime was necessary to mitigate the future risk of legionella.
- Neither gas nor electrical safety certificates were available on the day of inspection. Following the inspection the practice was able to locate the electrical installation safety certificate. However, it was unable to locate the gas safety certificate. The practice forwarded an email to the inspection team from the gas supplier that confirmed an inspection of the gas boiler in the property was completed in July 2016.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

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

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through audits and case discussions.

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 94% of the total number of points available, with a 5.5% exception reporting rate for the clinical domains (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).

Data from 2015/16 showed:

- Performance for diabetes related indicators was below the local and national averages. For example:
  - The percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 76% compared to the clinical commissioning group (CCG) and national average of 78%.
  - The percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the last year) was 140/80 mmHg or less was 74%, compared to the CCG average of 79% and national average of 78%.
  - The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 72% compared to the CCG average of 78% and national average of 80%.
  - The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 August to 31 March was 88% compared to the CCG average of 94% and national average of 95%.
  - The percentage of patients on the diabetes register with a record of a foot examination and risk classification within the last 12 months was 69% compared to the CCG average of 84% and national average of 89%.
- Performance for mental health related indicators was either in line with or above the local and national averages. For example:
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 90% compared to the CCG and national averages of 89%.
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 91% compared to the CCG and national averages of 89%.
  - The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 95% compared to the CCG average of 86% and national average of 84%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 84% compared to the CCG and national averages of 84%.
- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 77%, compared to the CCG and national averages of 76%.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients with COPD who had had a review undertaken including an appropriate assessment of breathlessness in the previous 12 months was 90%, compared to the CCG average of 87% and national average of 90%.

The GPs were aware that the practice had previously been an outlier for its QOF performance around COPD and diabetic cholesterol checks and told us that they were working to improve on these performance indicators, as demonstrated by the QOF results for 2015/16.

There was evidence of quality improvement including clinical audit. However, audit topic selection was ad-hoc and not systematic.

- There had been four clinical audits completed in the last two years, all of which were completed cycles where the improvements made were implemented and monitored.
- The practice participated in local audits, local and national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, the practice had recently completed an audit around the management of gestational diabetes. Action taken as a result included patients who required a blood test for appropriate management of the condition being identified and sent a blood form with a covering letter. This resulted in an increased percentage of this patient cohort (36 patients in total with a history of gestational diabetes) having appropriate blood results on record; an increase from 39% to 58%.

Information about patients' outcomes was used to make improvements. The practice proactively monitored its referral rates to ensure secondary care was being used appropriately. Following 27 patients being sent for lumbar spine x-rays in a six month period, the practice reviewed the outcomes and discovered that less than 10% were being returned as significantly abnormal. They concluded that these referrals were being overused and modified referral trends accordingly.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. Staff told us that this involved shadowing colleagues to enable them to become familiar with their role.
- The practice was unable to comprehensively demonstrate how it ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. No training certificates were available for the practice nurses or HCAs on the day of the visit. Following the inspection the practice provided evidence of update training for cervical smear taking for three of the five practice nurses. Evidence of immunisation and vaccination update training was provided for two of the nurses, although one of these was attended over 12 months ago and so was out of date. Despite it being requested, no evidence of any update training around the management of long term conditions was provided for any staff. No evidence of role-specific training for the two HCAs was provided by the practice.
- We were told that nursing staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence, although evidence of this was not provided. The practice did not demonstrate that staff who administered vaccines stayed up to date with changes to the immunisation programmes.
- The deputy practice manager told us that the learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. However, practice documentation indicated that 13 staff had not received an appraisal in the previous 12 months. We reviewed the personnel file of one of the HCAs who had been promoted from a receptionist into the role three years previously. There was no evidence of any appraisals being completed since becoming an HCA. This was confirmed in further discussions with the deputy practice manager. Following the inspection, the practice did provide a copy of a pre-appraisal questionnaire form, signed by both the HCA and one of the GPs that was dated July 2016.
- Staff received training that included: in house safeguarding training delivered by the GP safeguarding lead, fire safety awareness, basic life support and information governance.

Requires improvement

Are services effective?

(for example, treatment is effective)

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

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

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 75%, which was below the CCG and the national averages of 81%. 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 adding alerts to patient records to flag them up and facilitate opportunistic screening when they attended for other appointments. They also ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were slightly higher than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94.4% to 98.1% and five year olds from 88.9% to 96.6%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Privacy screens 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.

Of the 45 patient Care Quality Commission comment cards we received, 42 made positive remarks about the service experienced. Patients said they felt the practice offered a very good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one patient. 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 mostly responded compassionately when they needed help and provided support when required.

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

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 95% of patients said the GP gave them enough time compared to the CCG and the national average of 87%.
- 99% 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%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 91% 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. Patient feedback from the comment cards we received was also mostly positive and aligned with these views, although some felt clinicians did not always listen. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were slightly above local and national averages. For example:

- 90% 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%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 159 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example the practice had recently engaged in level three (specialist) diabetic care as well as offering anticoagulation monitoring for patients taking medication to reduce their risk of stroke. These services meant patients did not have to travel to hospital to attend specialist clinics.

- The practice offered extended hours appointments on a Saturday morning for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities and translation services available.
- A lift facilitated access to consultation rooms on the first floor of the building for those patients with mobility difficulties.
- A range of on-line services were offered by the practice; patients were able to book appointments online as well as request repeat prescriptions.
- Patients were able to register their mobile telephone numbers with the practice in order to receive appointment reminders via text message.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday, with surgeries offered between 9am and 11.30am each morning and 3.30pm until 5pm each afternoon. Extended hours appointments were available on Saturday mornings between 8.30am and 11.30am at Broadway Surgery. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. On the day of inspection, the next available pre-bookable routine appointment with a GP was in two days' time.

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

- 81% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 85% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People 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. A protocol was available to reception staff listing the characteristics of a home visit request which warranted the request being urgently flagged up to the on-call GP. Receptionists knew to take sufficient information from the patient to allow GPs to prioritise the need for a home 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

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. The complaints procedure was available on the practice website. It was also available behind the reception desk, although two of the reception staff we spoke to were unaware of its

Good

Are services responsive to people's needs?

(for example, to feedback?)

existence. When the document was located by a colleague, two versions were found and staff were unclear which was the current document containing the most up to date information.

The practice had received 11 complaints in the previous 12 months. We looked at one of these in detail and found it was satisfactorily handled, dealt with in a timely way,with openness and transparency. We saw that appropriate apologies were offered to patients when they had cause to complain, and saw evidence that patients were very appreciative of the apologies offered. Lessons were learnt from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, following a complaint made about review recall letters being sent to housebound patients, staff were reminded to ensure these housebound patients were coded appropriately on the record system to ensure further letters were not sent. Learning from complaints was shared with staff formally at the practice's annual complaints review meeting.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality, personalised and flexible care for patients.

- The practice stated this aim on its patient information leaflet and staff knew and understood the values.
- While we were told the practice had supporting business plans in place to reflect the vision and values, and that these were monitored regularly, when we asked to view them to corroborate this evidence they were not available.

The GPs told us of plans to expand the practice to new premises in the future to cope with increasing demand from a rising patient population in the local area. The practice had formulated a bid to secure new premises and were awaiting the outcome.

Governance arrangements

We found significant gaps in the governance framework within the practice, which led to concerns around the safety and effectiveness of the services being delivered. There were inadequate systems and processes in place to ensure the delivery of safe care.

- Practice specific policies were available put were poorly managed. There was limited evidence of regular, systematic review to update them in line with changes to legislation and local requirements. For example, the recruitment policy made reference to criminal records background checks being carried out; these checks have been superseded by DBS checks. Not all policies were marked with creation and review dates. We also found evidence of duplication, with the lack of control notation making it difficult for staff to ascertain which was the current document.
- While policies and procedures were stored on the practice's shared drive, staff we spoke to found it difficult to locate them, often needing to use the computer's 'search' function.
- Policy documents were not always comprehensive enough to cover the scope of the work carried out by the practice. For example, the infection prevention and control policy document made no reference to key responsibilities in this area including the cleaning of clinical equipment. The recruitment policy also lacked sufficient detail to effectively govern recruitment processes.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. However, audit topic selection was ad-hoc and not systematic.
- Arrangements for identifying, recording and managing risks were inadequate. Sufficient documentation had not been maintained by the practice for us to be assured that risks were being appropriately managed; for example no fire risk assessment or gas and electrical installation safety certificates were available.
- The practice demonstrated a lack of awareness of the legislation it had to adhere to around authorising non-prescribing clinical staff to administer medicines. We were told health care assistants administered vaccines but they did not do so in line with patient specific directions. The nurses did work to patient group directions, but the documents available to staff were not signed and we found that one document was out of date.
- The management of staff training was insufficient to ensure they had undertaken all that was required. The practice's training matrix document had key mandatory training topics omitted, such as infection prevention and control. The practice demonstrated a lack of understanding of the level of safeguarding training required. Staff training needs were not sufficiently assessed and many staff did not have a documented appraisal in the previous 12 months.

However, we did note that:

- An understanding of the clinical performance of the practice was maintained.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.

Leadership and culture

The partners told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

Are services well-led?

Inadequate

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

While the practice did not have a policy document around the duty of candour, the actions of the provider demonstrated it was aware of and ensured compliance with the duty's requirements (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice told us that when things went wrong with care and treatment it gave affected people support, truthful information and a verbal and written apology.

There was a clear leadership structure in place and staff told us they felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. We were told clinical team away days were held every 12 months.
- Staff said they felt respected, valued and supported by the partners and management staff at the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice had previously encouraged and valued feedback from patients, the public and staff. However, we saw limited recent activity to seek patient's feedback and engage patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys in the past. The practice showed us a report from the last patient survey, which was completed prior to March 2015. The most recent PPG meeting minutes displayed on the practice website were from August 2014. Staff confirmed to us that no PPG meetings had been held recently.
- The practice had gathered feedback from staff generally through staff meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, the nurses told us how the practice had purchased blood pressure monitors to allow them to more thoroughly assess patients. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a desire for continuous learning and improvement within the practice. The practice team was part of local pilot schemes to improve outcomes for patients in the area, for example the practice was involved in a pilot scheme trialling a patient records exchange system aiming to streamline patient records being passed between hospitals and GP practices.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** There was a lack of awareness of training requirements for staff at all levels with regards to safeguarding and as such, many staff had not received the appropriate level of training. This was in breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.