Rishton and Great Harwood Surgery

Quality Report

32 High Street
Rishton
BB1 4LA
Tel: 01254 617590
Website: www.rishtongp.com

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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

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Overall summary

Letter from the Chief Inspector of General Practice

Rishton and Great Harwood Surgery was inspected in September 2015. This inspection resulted in an overall rating of Requires Improvement, with an inadequate rating for the Safe domain. A Warning Notice was served against the provider on 26 October 2015. The provider was failing to meet the required standards relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment. In June 2016 we carried out a focussed inspection of the Rishton site to check the provider had taken the required action in relation to the Warning Notice, where we found not all the required action had been taken in relation to risk management and recruitment of staff.

We carried out an announced comprehensive inspection on 7 September 2016 in order to fully re-inspect and assess what progress had been made.

During this inspection we found that insufficient improvements had been made.

Overall the practice is now 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 systems were not in place to monitor patients being prescribed with high risk medication.
- We found that appropriate action was not being taken to safeguard vulnerable children.
- The practice lacked a clear system for reporting incidents, near misses and concerns and there was limited evidence of learning and communication with staff.
- Staff did not have access to appropriate training. The practice had not implemented a system of appraisals in order to assess training needs.
- There was limited awareness of the need to protect confidential information within the practice.
- The practice lacked leadership and had limited formal governance arrangements.

Summary of findings

- We received mixed feedback from patients about the manner in which clinical care was delivered by the GP
- Clinical audits demonstrated quality improvement.
- Patients were positive about their ability to access appointments at the practice.

The areas where the provider must make improvements are:

- Introduce more comprehensive processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- The provider must ensure safe and effective management of medicines to include timely medication reviews and documentation of associated blood results, a system for recording prescriptions and improved security for storage of blank prescriptions.
- Ensure that staff checking vaccine storage fridges are adequately trained and procedures in line with regulations for the safe management of vaccines.
- The provider must ensure that appropriate and current patient information is shared on request with external agencies in particular in relation to safeguarding concerns.
- The provider must ensure there is a system of formal and documented communication between GP and staff.
- Ensure all patient identifiable information is stored securely and disposed of appropriately.
- Put systems in place to ensure all staff have access to appropriate training and support.
- Ensure that an appropriate risk assessment for lone working staff is completed in regards to whether a DBS check needs to be undertaken.
- Ensure a thorough system of risk management is implemented. Risk assessments that indicate mitigating actions are required must be followed through. Gaps in the assessment of risk within the practice, such as a legionella risk assessment, must be addressed.

The areas where the provider should make improvement are:

- All policies should be included on the newly devised policy inventory in order to be sure that all practice policy documents are reviewed appropriately when needed.
- References requested as part of the recruitment process need to be clearly identified as to who has provided them and when.

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

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

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 was rated as inadequate for providing safe services following our inspection in September 2015. While improvements had been made in some areas, these were not sufficient and new concerns were identified.

The practice has again been rated as inadequate for providing safe services and improvements must be made.

- The practice had made some improvements around its provision of equipment and medication for use in an emergency. An oxygen cylinder had been purchased for use in a medical emergency, although only adult masks were available. The practice had also implemented a more structured system of checks to ensure emergency equipment was functional and emergency medication was in date.
- Staff told us of examples where they had raised concerns regarding incidents or near misses that were not acknowledged or investigated by the GP. When significant events were acknowledged and written up, we saw limited evidence of learning or action being taken following these to mitigate against them being repeated.
- Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe. For example we found instances where high risk medication had been prescribed to patients without appropriate medication reviews taking place, or appropriate blood test results being available.
- We saw evidence that the GP had not responded appropriately to requests for information by the health visitors regarding vulnerable children. Follow up actions had not been carried out when these children failed to attend appointments, or attended out of hours healthcare provision. We saw one example of a record of a vulnerable child's consultation with the GP having been documented in the wrong medical record.
- There was insufficient attention to safeguarding children and vulnerable adults. While the GP had now been trained appropriately in this area, three of the six reception staff had not received any training around safeguarding children.
- Non clinical staff were not routinely checked through the Disclosure and Barring Service (DBS). These staff would be asked to carry out chaperone duties. While the practice had

Summary of findings

documented risk assessments deeming that DBS checks were not required for their roles, this was not in keeping with the practice's chaperone policy which stated all staff who acted as chaperones must have a DBS check in place.
- The practice had made some improvements around its recruitment processes. For example, references were now being sought.

Are services effective?

Inadequate

The practice was rated as good for providing effective services following our inspection in September 2015. However, we found areas of concern so the practice is now rated as inadequate for providing effective services, as improvements must be made.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Clinical audits demonstrated some quality improvement.
- Staff did not always assess needs and deliver care in line with current evidence based guidance.
- There was minimal engagement with other providers of health and social care.
- Staff did not feel that the induction process offered to new employees was sufficient to ensure competence given the high level of lone working expected of them.
- Staff raised concerns with us about how their shift patterns were managed. They told us they often received last minute telephone calls insisting that they attend for a shift they had not been scheduled to work.
- There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.

Are services caring?

Requires improvement

The practice was rated as good for providing caring services following our inspection in September 2015. However, we found areas of concern so the practice is now rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the national GP patient survey showed patients rated the practice in line with others for most aspects of care.

Summary of findings

- Patients said on the day of the inspection they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However, patient comment cards did not align with this feedback, where concerns were expressed regarding the manner of the GP.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect.
- The practice did not assure us that patient and information confidentiality was maintained.

Are services responsive to people's needs?

Requires improvement

The practice was rated as good for providing responsive services following our inspection in September 2015. However, we found areas of concern so the practice is now rated as requires improvement for providing responsive services, as there are areas where improvements should be made.

- Information about how to complain was available and easy to understand. However, the complaints procedure offered no guidance about how verbal complaints should be managed. The practice told us that no complaints had been received in the last year. The staff told us of examples where patients had been dissatisfied with their care and treatment but that had been resolved verbally. These verbal complaints had not been documented so it was unclear whether learning had been identified as a result. Therefore, learning opportunities from patient feedback and complaints were not maximised.
- 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.
- Patients praised the available access at the practice. They said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had appropriate facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

In September 2015 the practice had been rated as requiring improvement for being well led. There had been concerns around the governance arrangements and leadership within the organisation. The practice had not made sufficient improvements in this area and is now rated as inadequate for being well-led.

Summary of findings

- While there was a staffing structure in place, there was a lack of leadership capacity. Staff were not fully clear about all their roles and responsibilities nor did they feel supported by management.
- The practice had a number of policies and procedures to govern activity, but while some improvements had been made around document control, the new systems implemented were not fully effective. There remained policies that were overdue a review and we found examples of policies that were not practice specific and did not reflect practice procedures.
- The practice had held four staff meetings in the previous nine months. However, the GP had only attended one of these and we saw evidence in the meeting minutes of recurring issues around administrative concerns that had not been addressed.
- The practice had not proactively sought feedback from staff or patients. There was only limited engagement with the practice's patient participation group.
- Staff told us they had not received regular performance reviews or appraisals and did not have clear objectives. There remained significant gaps in staff training.

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 providing safe, effective and well-led services and requires improvement for providing responsive and caring services. The issues identified as requiring improvement affects all patients including this population group.

However:

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and home visits were facilitated via the over 75s nurse employed by the CCG. Urgent appointments were available for those with enhanced needs.
- Patients over the age of 75 were offered a care plan.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive and caring services. The issues identified as requiring improvement affects all patients including this population group.

However:

- The GP led on the management of all patients with long term conditions in the practice.
- Patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was generally higher than the local and national averages.
- Longer appointments and home visits were available when needed.
- These patients had a named GP and were offered structured annual review to check their health and medicines needs were being met.
- However, we found numerous examples where high risk mediation was prescribed on repeat without appropriate medication reviews having been completed or blood test results sourced.

Summary of findings

Families, children and young people

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive and caring services. The issues identified as requiring improvement affects all patients including this population group.

- There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We found examples of scenarios which should have triggered joint working with health visitors and school nurses. However, this did not happen meaning vulnerable children were put at risk.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive and caring services. The issues identified as requiring improvement affects 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 offered two evenings per week for those patients who could not attend during normal working hours.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive and caring services. The issues identified as requiring improvement affects all patients including this population group.

- There was no evidence that the practice worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. There were numerous information leaflets and posters displayed in the waiting room.
- Non-clinical staff told us they knew how to recognise signs of abuse in vulnerable adults and children. They demonstrated they were aware of their responsibilities in conversation regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, we noted there were gaps in staff training around safeguarding adults and children.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive and caring services. The issues identified as requiring improvement affects all patients including this population group.

However:

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 100% compared to the CCG average of 82% and national average of 84%.
- 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 92% compared to the CCG average of 89% and national average of 88%.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 328 survey forms were distributed and 100 were returned. This represented a response rate of 30.5% and 8.5% of the practice's patient list.

- 99% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 99% 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%.
- 88% of patients described the overall experience of this GP practice as good compared to 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 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 six comment cards, of which three were positive about the standard of care received, praising the practice for the fact that appointments were always available when needed. The other three comment cards made reference to the GP's poor manner with patients, stating that he could be rude to both patients and other staff and that he was argumentative and not always receptive to the views of the patient.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and told us how the GPs made onward referrals quickly.

Feedback received by the practice via the Friends and Family Test indicated that 86% of patients who responded would recommend the practice to their friends and family, while 14% would not.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Introduce more comprehensive processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- The provider must ensure safe and effective management of medicines to include timely medication reviews and documentation of associated blood results, a system for recording prescriptions and improved security for storage of blank prescriptions.
- Ensure that staff checking vaccine storage fridges are adequately trained and procedures in line with regulations for the safe management of vaccines.
- The provider must ensure that appropriate and current patient information is shared on request with external agencies in particular in relation to safeguarding concerns.
- The provider must ensure there is a system of formal and documented communication between GP and staff.
- Ensure all patient identifiable information is stored securely and disposed of appropriately.
- Put systems in place to ensure all staff have access to appropriate training and support.
- Ensure that an appropriate risk assessment for lone working staff is completed in regards to whether a DBS check needs to be undertaken.
- Ensure a thorough system of risk management is implemented. Risk assessments that indicate mitigating actions are required must be followed through. Gaps in the assessment of risk within the practice, such as a legionella risk assessment, must be addressed.

Summary of findings

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- All policies should be included on the newly devised policy inventory in order to be sure that all practice policy documents are reviewed appropriately when needed.
- References requested as part of the recruitment process need to be clearly identified as to who has provided them and when.

Rishton and Great Harwood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Rishton and Great Harwood Surgery

Rishton and Great Harwood surgery offers services from both a main surgery in Rishton as well as a branch surgery in Great Harwood Health Centre in Great Harwood. Patients can access services at either premises. The inspection visit took place at the main Rishton surgery, which is housed in a terraced commercial property on the high street of the town.

The practice delivers primary medical services to a patient population of 1177 under a general medical services (GMS) contract with NHS England. The practice caters for a higher proportion of patients experiencing a long standing health condition, 65%, compared to the local average of 58% and national average of 54%. The average life expectancy of the practice population is higher than the local average, but lower than the national average for both males and females (78 years for males, compared to the local average of 77 years and national average of 79 years. For females, 82 years, compared to the local average of 81 and national average of 83 years). The age distribution of the practice population closely mirrors the local and national averages.

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

The practice is a partnership, with one male partner GP working full time and one female partner GP who works one afternoon per week. The practice does not employ any practice nurses, but patients can access appointments with nurses whose posts are funded by the Clinical Commissioning Group (CCG). These nurses run clinics based at Great Harwood Health Centre, which is the same building that houses the practice's branch surgery. The GPs are supported by non-clinical staff consisting of two part time senior administrators and six receptionists. The practice is also supported for half a day per week by the CCG's advanced locality pharmacist.

The practice is open between 8:00am and 6:00pm Monday to Friday, apart from Wednesday and Friday when extended hours are offered until 7:00pm, and Thursday when it closes for the afternoon at 12:30pm. Appointments are from 9:00am to 5:30pm each day, although surgeries are split between the main and branch surgeries. Extended hours surgeries are offered until 7:00pm on Wednesdays and Fridays. When the practice is closed, patients are able to access out of hour's services offered locally by the provider East Lancashire Medical Services.

The practice had previously been inspected on 23 September 2015, when a full comprehensive inspection was completed. This visit resulted in a Warning Notice being served against the provider on 26 October 2015. The

Detailed findings

Notice advised the provider that the practice was failing to meet the required standards relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

On 17 June 2016 we carried out a focussed inspection of the Rishton site to check the provider had taken the required action in relation to the Warning notice which we issued on 26 October 2015. At this inspection we found that some improvements had been made, but that some concerns also remained.

When we returned for our most recent visit we noted that the previously awarded ratings were not displayed, either in the surgery premises or on the practice website.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 September 2016. During our visit we:

- Spoke with a range of staff including the lead GP and three reception and administrative 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

During our visit in September 2015, we found that the practice's system for reporting and recording significant events was not comprehensive. The findings from our most recent inspection meant that we have ongoing concerns in this area. There were six documented significant events for the previous 12 months.

- Staff told us they would inform the GP or lead administrator of any incidents and there was a recording form available on the practice's computer system. However, staff were not clear regarding who had responsibility for writing up the details of the event. The incident recording form did not support the recording of notifiable incidents under the duty of candour (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw no evidence to suggest 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.
- The practice's analysis of the documented significant events was not comprehensive. Documentation indicated that no action was taken or changes to practice implemented for four of the events, despite them representing a trend of administrative errors such as prescriptions being duplicated and incorrect information being placed in patient records.

While it was documented that information regarding the events was fed back to staff, this was not done in a timely manner in order to minimise the risk of the events being repeated. For four of the events that occurred between December 2015 and January 2016, we saw that feedback was given to staff at a meeting in June 2016. Staff we spoke with were unable to give us specific examples of significant events that had recently occurred.

Staff gave us examples of other incidents, for example a patient requesting a form for a blood test at the request of the GP, where no information relating to this was documented in the patient record. Staff told us that the GP did not feel this needed to be written up as a significant event.

Overview of safety systems and processes

In September 2015, we found gaps in the practice's safety systems. During our most recent visit we did see that some improvements had been made following the previous inspection. However we found other areas of concern that demonstrated the practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- The practice still did not have comprehensive arrangements in place to safeguard children and vulnerable adults from abuse. In September 2015 we found that the GPs had not received safeguarding training to the required level. The GP could now demonstrate he was trained to child protection or child safeguarding level three. However, three of the practice's reception staff, whose roles involved them working alone for extended periods of time, whilst patients had access to the premises, had not received any child safeguarding training. Only one of these three staff members had received adult safeguarding training. Policies were accessible to all staff which clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The staff we spoke to were aware of these. The lead GP took lead responsibility for safeguarding. We reviewed three records of children on child protection plans and found that they were not being managed appropriately. These patients were not routinely followed up after attending an out of hours service or when they failed to attend an appointment. We found an example where a health visitor had requested information from the GP. The GP had responded to the health visitor in writing requesting that they bring the family to the practice for a consultation. This visit had not happened and no further follow up had been documented in the patient record. We found one example where correspondence relating to a child, as well as the consultation notes, were recorded in the child's parent's record rather than the child's own record.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones had been trained for the role two

days prior to the inspection visit. However, only three of the six staff 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). These checks had all been completed by other healthcare employers. The practice's own chaperone policy stated that all staff acting as chaperones must have had a DBS check completed.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection control protocol in place, however this was not fully practice specific, referencing another GP practice and a practice manager (a post that did not exist in the practice). Only one member of staff had received up to date training. In September 2015 it was found that an infection prevention and control audit had not been completed. In June 2016 we found an infection control audit had been completed in December 2015. However, at that time actions resulting from it had not been fully completed. We saw during our most recent visit that these actions were now completed.
- Risks associated with the management of medicines, including emergency medicines and vaccines, in the practice were not appropriately mitigated (including obtaining, prescribing, recording, handling, storing, security and disposal). 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. We reviewed the patient records of six patients being prescribed high risk medicines and found that in four of these cases the medication was not being prescribed safely. We found that prescriptions had been issued without medication reviews being completed, and without relevant blood results being documented and reviewed to ensure the prescriptions were appropriate. In two cases it was unclear whether the patients had any medicines prescribed. Staff meeting minutes from 28 July 2016 indicated that reception staff had been adding medication to patient records. Blank prescription forms and pads were securely stored and while there were systems in place to monitor their use, these systems had not been implemented effectively. A log was kept with the blank scripts in order to document who had removed any blank scripts. However, the noted serial numbers of the scripts did not correspond to those in the GP's bag. On the day of inspection we became aware that the GP had left his bag containing emergency medication and blank prescription forms unattended in his locked car.
- Receptionists had the responsibility of checking and documenting the vaccine fridge temperatures each day. We noted there had been a recent significant event around the vaccine fridge temperatures being too high. The upper temperature readings logged had been outside the accepted range over the previous four months. We discussed the cold chain procedure with reception staff who informed us they were aware of the appropriate temperature range for the fridge. They told us that if the temperature was too high, they would adjust the fridge setting to lower the temperature and re-set the temperature logger. They did not say they would inform the GP in this instance. The practice had not considered the possibility that the equipment was not functioning as it should.
- In September 2015 and June 2016 we had found the practice's recruitment processes to be unsafe. On our most recent inspection we reviewed personnel files of two staff recruited to the practice since July 2016 and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, and qualifications. We did note some gaps with the documentation of references; of the four references documented for the two staff, three did not document who had provided the reference or the date when it had been provided.
- There was no record of a DBS check having been completed for three of the reception staff. A risk assessment was documented in their personnel files stating that these staff worked under a high level of supervision and that contact with service users was regular but infrequent. These risk assessments were not signed by the employees. We spoke to two members of reception staff who both confirmed that they worked alone for extended periods of time and that they dealt with patients throughout this time.

Monitoring risks to patients

While there had been some improvement with how risks to patients were assessed and managed since September 2015, some areas of concern remained:

Inadequate

Are services safe?

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the premises which identified local health and safety representatives. During the previous inspection visit in September 2015 there had been concern around the practice's management of fire safety. However, the practice now had up to date fire risk assessments and carried out regular fire drills and tested fire safety equipment. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- While the practice had formulated other risk assessments in order to monitor the safety of staff, we saw that these documents did not always specify mitigating actions once a risk had been identified and where actions had been identified, they had not been completed. For example a health and safety risk assessment document identified that staff were at risk of abuse from patients and stated this risk would be mitigated by staff accessing conflict resolution training. We did not see evidence that this training had been accessed by staff.
- A legionella risk assessment had not been completed for the premises (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). There was a policy document relating to legionella which had been produced by the property management company responsible for Great Harwood Health Centre, where the practice's branch surgery was located, but had no involvement with the main practice premises. Although the practice carried out monthly water temperature checks and we saw that these checks were documented, it was not possible to confirm this was an appropriate legionella control regime for the premises without a legionella risk assessment.

Arrangements to deal with emergencies and major incidents

The practice had improved its arrangements to respond to emergencies and major incidents since our inspection in September 2015.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Three of the six non-clinical staff had received basic life support training in the previous 12 months and there were emergency medicines available in the GP's consultation room.
- The practice had a defibrillator available on the premises and had purchased an oxygen cylinder since the September 2015 visit. However, there were only adult masks available for use with the oxygen. A first aid kit and accident book were available, although not all staff were aware of the location of the accident book.
- 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. The plan included emergency contact numbers for staff and external contractors.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At the previous comprehensive inspection in September 2015 this domain was rated as good. However, during this inspection we found areas of concern.

Effective needs assessment

The GP told us how he accessed information in order to ensure patient's needs were assessed and care delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. For example the GP explained how he now ensures patient's blood pressure is monitored appropriately in keeping with updated guidance. The practice monitored that these guidelines were followed through audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95.9% of the total number of points available, with a 5.4% 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).

This practice was not an outlier for any QOF clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was generally higher than 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 72% compared to the clinical commissioning group (CCG) average of 79% 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 95%, compared to the CCG average of 80% 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 93% compared to the CCG average of 84% and national average of 81%.
  - The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 August to 31 March was 98% compared to the CCG average of 95% and national average of 94%.
  - The percentage of patients on the diabetes register with a record of a foot examination and risk classification within the last 12 months was 98% compared to the CCG average of 89% and national average of 88%.
- Performance for mental health related indicators was higher than the national average. 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 92% compared to the CCG average of 89% and national average of 88%.
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 100% compared to the CCG average of 90% and national average of 90%.
  - The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 100% compared to the CCG average of 82% 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 95% compared to the CCG average of 85% and national average 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 91%, compared to the CCG average of 76% and national average of 75%.

Data from the Health and Social Care Information Centre (HSCIC) for 2014/15 identified the practice as an outlier for

Inadequate

Are services effective?

(for example, treatment is effective)

its ratio of reported verses expected prevalence for Chronic Obstructive Pulmonary Disease (COPD) (Practice ratio of 0.47, compared to the local average of 0.86 and national average of 0.63).

There was evidence of quality improvement including clinical audit.

- There had been four audits completed in the last year, two of these were completed clinical audits where the improvements made were implemented and monitored.
- The practice participated in local audits and national benchmarking.
- Findings were used by the practice to improve services. For example, action taken as a result of a recent asthma audit included inviting patients in for consultations to educate them on how to best use their inhalers. The practice demonstrated, through monitoring the numbers of patients who were 'high-users' of their reliever inhalers (those that needed more than 12 prescriptions within a 12 month period) that this education improved the control of these patient's asthma. The number of patients requiring 12 prescriptions or more fell from seven to three.

Information about patients' outcomes was used to make improvements. For example, after two patients had been diagnosed with haemochromatosis (a disorder in which iron salts are deposited into tissue which can lead to liver damage), the practice audited the ferritin results of 239 patients (ferritin levels in blood can indicate whether a patient has an iron storage disorder) and reviewed patients with high ferritin levels in order to ensure appropriate referrals to secondary care for other patients were made as required.

Effective staffing

We were not assured that all staff had the skills, knowledge and experience to deliver effective care and treatment.

- While the practice did have an induction programme for all newly appointed staff, staff told us they did not feel it was sufficient to ensure competency in the role, given the high levels of lone working undertaken. New staff were given the opportunity to shadow colleagues for two weeks before they were expected to work alone carrying out their reception and administrative duties. The main surgery and branch were both staffed by a single member of administrative / reception personnel.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Since the practice did not employ its own practice nurse, the GPs carried out long term condition reviews.
- The female GP partner took responsibility for administering vaccines. However, the lead GP was unable to demonstrate how they stayed up to date with changes to the immunisation programmes. The lead GP informed us that the female GP partner had not attended any immunisation and vaccination update training for some years, since the Primary Care Trust had been in existence.
- The practice was unable to demonstrate how the learning needs of staff were identified. While we saw that for the two most recently recruited members of staff, a six week performance review interview had taken place and been documented, no other staff had received an appraisal in the previous 12 months. Staff did not have access to appropriate training to meet their learning needs and to cover the scope of their work.
- During our September 2015 inspection we identified that systems around the management of staff training were not effective. While some training for staff had since been arranged, we found that there were still significant gaps in the management of training during our most recent visit. Training which had been completed included safeguarding training for GPs and basic life support, chaperone and fire training for staff. However, only three of the non-clinical staff had received safeguarding children or adults training, and despite the practices own health and safety risk assessment stating that reception staff required access to conflict resolution training, this had not been undertaken by four of the six staff members.
- While there was a rota system in place to ensure there were sufficient staff on duty, staff raised concerns with us about how this rota was managed. Shift patterns were scheduled four weeks in advance, but staff told us that they frequently received phone calls from the GP at

the last minute insisting that they work a shift on a day they had not been scheduled to do so. The inspection team became aware that this had happened on the day of the inspection visit.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- When records were reviewed by the inspection team we found examples where not all patient contact had been included in the clinical record, for example telephone conversations that had not been written up.
- The practice did not always share relevant information with other services in a timely way, for example when requests were received for information from health visitors.

There was limited evidence that the GPs worked 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. We found numerous examples where vulnerable patients had attended out of hours care settings but had not been followed up by the practice. We saw no evidence that any multi-disciplinary meetings had taken place since our visit in September 2015.

Consent to care and treatment

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

- The practice had a Do Not Attempt Cardiopulmonary Resuscitation policy, which made reference to the Mental Capacity Act 2005 (MCA 2005). The GP informed us he had attended MCA training two years ago.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Supporting patients to live healthier lives

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

- 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 80%, which was comparable to the CCG and national averages of 82%. The practice's patients accessed the cervical screening appointments offered by the CCG commissioned treatment room service in Great Harwood Health Centre, the building where the practice's branch surgery was located. The practice did not have a failsafe system in place to ensure results were received for all samples sent for the cervical screening programme. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were variable compared to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 30% to 100% (compared to national average rates which ranged from 73.3% to 95.1%) and five year olds from 62% to 100% (compared to the national rated that ranged from 81.4% to 95.1%).

Patients had access to appropriate health assessments and checks with the GP. 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.

Requires improvement

Are services caring?

Our findings

At the previous comprehensive inspection in September 2015 this domain was rated as good. However, during this inspection we found areas of concern.

Kindness, dignity, respect and compassion

We observed reception 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.

However, we did find that patient identifiable information was not maintained securely. The practice used templates printed on reused paper for receptionists to populate with patient details when patients were making a request, for example for an acute prescription. These slips of paper were then handed between reception staff and GP. As well as representing a method of communication that did not leave an appropriate audit trail, we found that these re-used pieces of paper also had patient identifiable information on the reverse side relating to other patients. We saw that these slips were not routinely shredded, instead placed in domestic waste bins.

Three of the six patient Care Quality Commission comment cards we received were positive about the service experienced. These patients said they were satisfied with the care they received and found the reception staff to be helpful and caring. The other three comment cards we received referenced concerns regarding the manner of the GP, describing this as argumentative and rude.

We spoke with two patients during the inspection visit. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- However, 6% said that the GP was poor at listening to them, compared to the CCG average of 4% and national average of 4%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 84% 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%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us via comment cards that they did not always feel involved in decision making about the care and treatment they received. However, the two patients we spoke to during the inspection 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.

While we saw that care plans were documented for vulnerable patients, these lacked detail in terms of clinical information. Two out of the three patients with care plans in place whose patient records we reviewed had attended for out of hours medical support but had not been followed up by the GP.

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:

Requires improvement

Are services caring?

- 81% 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%.
- However, 8% of patients said the last GP they saw was poor at explaining tests and treatments compared to the CCG average of 4% and national average of 3%.
- 84% 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%.

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

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 about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 78 patients as carers (6.6% 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, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At the previous comprehensive inspection in September 2015 this domain was rated as good. However, during this inspection we found areas of concern.

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.

- The practice offered extended hours appointments on a Wednesday and Friday evening until 7.00pm 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. These were predominantly offered by the over 75s nurse who visits patients registered with a number of practices within the locality.
- 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, a hearing loop and translation services available.
- All treatment and consultation rooms were situated on the ground floor in the main surgery premises.
- Text message reminders were sent to patients to promote attendance at appointments if they had a mobile telephone number registered with the practice.
- The practice had a mobile telephone which facilitated direct contact with the GP for medical advice over the telephone should a patient not be able to attend the surgery in person.

Access to the service

The practice was open between 8:00am and 6:00pm Monday to Friday, apart from Wednesday and Friday when extended hours were offered until 7:00pm, and Thursday when it closed for the afternoon at 12:30pm. Appointments were offered from 9:00am to 5:30pm each day, although surgeries were split between the main and branch surgeries. Extended hours surgeries were offered until 7:00pm on Wednesdays and Fridays. In addition to pre-bookable appointments that could be booked 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.

- 92% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 99% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 99% of patients said the last time they wanted to see or speak to a GP or nurse at the practice they were able to get an appointment, compared to the national average of 76%.

Patients we spoke with and those who completed comment cards praised the availability of appointments at the practice. People told us on the day of the inspection that they were always able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a complaints policy and procedure however this did not offer guidance on the management of verbal complaints. The lead GP was the designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system; a complaints leaflet for patients was available in the reception area.

There had been no documented complaints in the previous 12 months. However, staff told us of examples where patients had expressed dissatisfaction with their care and treatment. We were told that these concerns were resolved verbally between the GP and patient concerned. The decision had been made by the GP not to write them up, so it was unclear whether any learning had been identified or changes implemented as a result. It was unclear whether an apology had been offered to the patients concerned. There was no system in place for reception staff to document and record verbal complaints. Therefore, learning opportunities from patient feedback and complaints were missed.

Are services well-led?

Inadequate

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

Our findings

At the previous comprehensive inspection in September 2015 this domain was rated as requires improvement. During this most recent inspection we found areas of ongoing concern.

Vision and strategy

The practice's statement of purpose set out the vision of the organisation to offer patients an excellent standard of clinical and personal care. While there was no mission statement displayed in the premises, staff told us how they were proud of the personalised care they were able to offer as they had the chance to get to know the patient population well.

Governance arrangements

Following our inspection visit in September 2015, we found there were gaps in the governance systems of the practice. While we saw that efforts had been made to make improvements, the governance arrangements remained weak:

- There was a staffing structure in place.
- We found evidence that indicated staff were not fully aware of their own roles and responsibilities. For example staff meeting minutes from 28th July 2016 indicated that reception staff had been adding new medication to patient notes without consulting with the GP.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- There had been some improvement around how policies were implemented and the documents monitored and controlled. For example, the practice had implemented a policy register to document when policies were due for review. However, we noted that this system was not implemented effectively. A number of the practice's policies, such as the consent policy and business continuity plan were not included on this register. We found a number of policy documents that stated they were due for review in July 2016, but these reviews had not been completed (for example the Safeguarding Adults and DNACPR policies). It remained the case that some policies contained information that was not specific to the practice, for example the infection prevention and control policy referred to Queensway Medical Centre as well as referring to a practice manager, despite the practice manager role not existing at Rishton and Great Harwood Surgery.
- We found evidence that the practice was not consistently following its own policies. For example, the chaperone policy stated that all non-clinical staff who acted as chaperones must have a DBS check carried out.
- The practice had failed to ensure thorough arrangements were in place for identifying, recording and managing risks, issues and implementing mitigating actions. For example the health and safety risk assessment that had been produced identified a number of risks; in some cases action points to mitigate these risks had not been identified, and in some cases where actions had been identified they had not been completed (for example lone-working reception staff had not undertaken conflict resolution training).

Leadership and culture

Patients told us via feedback on comment cards that the GP was at times rude to staff. Staff were aware that at times there was confusion around processes within the practice between the GP and administrative staff, and described how the GP could become frustrated when misunderstandings occurred.

There was a clear leadership structure in place, but staff told us they did not always feel supported by management. Staff described the lead administrators in the practice as extremely approachable. However, each of the two lead administrators were only employed for six hours per week, so for much of the time they were not accessible.

- We saw that four staff meetings had been held in 2016. However, the lead GP had only attended one of these.
- There was limited opportunity for staff to raise any issues or concerns. Staff told us the GP could be rigid in the way that he worked and was therefore not always open to changes being put in place. We saw examples from staff meeting minutes from meetings in June 2016 and July 2016 that documented ongoing themes of concerns around administrative tasks not being completed. The GPs were not in attendance at either meeting and no further action had been taken to resolve the issues raised.

Are services well-led?

Inadequate

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

- Staff told us they felt frustrated, particularly with how pre-planned shift patterns were frequently changed with little or no notice.

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

The GP informed us that no patient surveys had been carried out since the September 2015 inspection visit, as he felt that patients were being asked for their feedback via a number of other channels and as such was being 'overdone.'

- There was a patient participation group. Staff told us that this consisted of eight patients. However, it was not active. A meeting had been held two days before the inspection visit which was attended by four of the members, but staff told us that prior to this the last meeting had been in 2015.
- There was a suggestion box in the reception area for patients to offer feedback, but staff we spoke to were not aware of any patient feedback that had been received through this.
- Staff were unable to offer any examples where they had given feedback to the GP that had resulted in any changes to how the organisation was run. The fact that the GP only infrequently attended staff meetings, and that most staff had not received appraisals meant that staff had limited opportunities to raise any concerns or make suggestions regarding improvements to practice processes.

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not ensure medicines were managed appropriately. Appropriate and timely management of patients on high risk medications, including medication reviews and documentation of associated blood results, had not occurred. We also saw that non-clinical staff had been adding new medication to patient records. The provider did not ensure that appropriate and current patient information was shared on request with external agencies in particular in relation to safeguarding concerns. The provider had not ensured an appropriate system was followed to log and identify the location of any blank prescription pads. The provider did not ensure a thorough system of risk management was implemented. Risk assessments that indicated mitigating actions were required were not all followed through. There were gaps in the assessment of risk within the practice, for example no legionella risk assessment had been completed. Regulation 12(1)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Comprehensive processes for reporting, recording, acting on and monitoring significant events, incidents and near misses were not implemented.

This section is primarily information for the provider

Enforcement actions

Communication channels between staff and the GP were not sufficient.

The provider had not ensured that an appropriate risk assessment for lone working staff had been completed in regards to whether a DBS check needs to be undertaken.

The provider had not ensured all patient identifiable information was stored securely and disposed of appropriately.

Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Family planning services	How the regulation was not being met:
Maternity and midwifery services	Staff did not have access to appropriate training and support to ensure competence in their roles.
Treatment of disease, disorder or injury	Regulation 18(1)