Manchester Road Surgery

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Manchester Road Surgery on the 26 November 2015. The overall rating for the practice was requires improvement, with key questions Safe, Effective and Well Led rated as requires improvement. The inspection identified that recruitment arrangement and staff training and support was not good enough. A planned programme of clinical audit was not implemented. The identification and management of risk needed improving and systems to ensure single use equipment had not passed their expiry date were not in place. Systems to ensure GPs reviewed patient prescriptions added to the patient electronic record by administration staff were not in place. We issued four requirement notices for breaches of regulation and the practice submitted an action plan detailing how they intended to improve the service they provided. The full comprehensive report on the November 2015 inspection can be found by selecting the 'all reports' link for Manchester Road Surgery on our website at www.cqc.org.uk.

This inspection was a follow up announced comprehensive inspection on 10 May 2017. Overall the practice is now rated as Inadequate.

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

- Since the last inspection the practice had improved the system for reporting and recording significant events and ensuring all staff were made aware of any learning and improvement from incidents.
- Actions undertaken by the practice to ensure health care risks for patients were minimised were inadequate. For example there was no safeguarding policies available specific to the practice and contact telephone numbers to local safeguarding teams were not available except in one GP consultation room. Safeguarding registers for children or vulnerable adults were not maintained and GPs could not tell us how many children were designated at risk or how many had a child protection plan in place.

Summary of findings

- Systems to ensure patients received timely medication reviews and the appropriate health care checks such as blood tests were not in place potentially putting patients at risk.
- Recorded care plans were not available, checks to monitor patients prescribed high risk medicines such as disease-modifying anti-rheumatic drugs (DMARDs) were disorganised and checks to monitor patients referred urgently to see a specialist on the two week pathway were reactive.
- Improvements had been made to staff recruitment checks since the last inspection. Recruitment records included Disclosure and Barring Service checks (DBS) for staff employed at the practice.
- Staff had received an annual appraisal since the last inspection and clear evidence was available of the training staff had received. However GPs confirmed that they had not had health and safety training including fire safety and records to demonstrate they had had infection control and prevention training were not available.
- Urgent appointments were usually available on the day they were requested. Although patients told us that getting a routine appointment was difficult.
- The practice's policies and procedures had been reviewed but we noted these were generic policies and were not adapted to reflect the practices procedures.
- Parts of the practice environment was in need of refurbishment, however a maintenance or refurbishment plan was not in place.
- Governance arrangements to monitor and review the service provided were not effective and this had resulted in gaps in service delivery and performance.
- The practice had updated their complaints policy since the last inspection. However the policy was incomplete and the practice procedure did not align with their policy.
- Staff confirmed they attended two to three monthly team meetings which they found useful.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients
- Ensure patients are protected from abuse and improper treatment
- Ensure there is an effective system for identifying , receiving ,recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

In addition the provider should:

- Improve procedures to reflect national good practice in obtaining a written consent before minor surgery is undertaken.
- Strengthen the practice's procedure to safeguard both patients and GPs by recording within the patient record a note of the patients' blood clotting rate (INR), the dose of medicine prescribed and when the next check was due.
- Establish a rolling programme of regular clinical audit and re-audit.
- Develop the practice's patient reference group to provide opportunities for more participation by holding face to face meetings.
- Develop the practice's policy on equality to ensure patients have access to independent interpreting services.

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

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

Summary of findings

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

At our previous inspection on the 26 November 2015 we rated the practice as requires improvement, with key questions Safe, Effective and Well Led rated as requires improvement. We found that systems and processes to address these risks were not implemented well enough. For example recruitment checks to were not always carried out, infection control audits were not undertaken and the appropriate building checks were not in place such as gas and electrical safety certificates.

Some arrangements had improved when we undertook a follow up comprehensive inspection on 10 May 2017. However, other gaps in service provision were identified. The practice is now rated as inadequate for providing safe services.

- Since the last inspection the practice had improved the system for reporting and recording significant events and ensuring all staff were made aware of any learning and improvement from incidents.
- Actions undertaken by the practice to ensure health care risks for patients were minimised were inadequate. Safeguarding policies were generic and did not contain contact telephone numbers to the local safeguarding teams. The practice were unable to demonstrate that they had an overview of those children with a child protection plan in place.
- Patients did not always receive timely medication reviews and the appropriate health care checks such as blood tests and care plans were not available for vulnerable adults. Following our inspection the practice supplied an action plan and had scheduled reviews to ensure patients who required health care checks were monitored.
- Improvements had been made to staff recruitment checks since the last inspection. Recruitment records included Disclosure and Barring Service checks (DBS) for staff employed at the practice.
- Infection control audits had been carried out, although actions to mitigate the risks identified were not implemented or planned for.
- Staff training records had improved since the last inspection however the GPs and the practice cleaner had not received fire safety training or infection control training.
- The risk assessment for the use of liquid nitrogen needed improving and a lone worker risk assessment was not available.

Summary of findings

Are services effective?

Inadequate

At our previous inspection on the 26 November 2015 we rated the practice as requires improvement, with key questions Safe, Effective and Well Led rated as requires improvement. We found that there was little evidence that audit was driving improvement in performance to improve patient outcomes and appraisals were not monitored and not all staff had completed their yearly appraisal.

Some arrangements had improved when we undertook a follow up comprehensive inspection on 10 May 2017. However, other gaps in service provision were identified. The practice is now rated inadequate for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes reflected the local and the national average. However the practice's exception reporting was significantly higher for a number of performance indicators when compared to local and national averages.
- Since the previous inspection there had been one completed two cycle clinical audit and one, first cycle clinical audit undertaken which were used to drive improvements. However a clinical audit plan was not in place.
- Records showed that patients did not get timely medication reviews or the required health checks potentially putting patients at risk. Following the inspection the practice informed us that patients had been contacted and they supplied an action plan to undertake these outstanding reviews.
- Systems to recall patients prescribed high risk medicines were disorganised, and checks to monitor patients referred on the two week pathway were reactive.
- Staff had received an annual appraisal since the last inspection and clear evidence was available of the training staff had received
- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However the practice did not obtain or request a written consent from patients before they underwent minor surgery procedures.

Are services caring?

Good

At our previous inspection on 26 November 2015 we rated the practice as good for providing caring services as data showed patients were generally satisfied with the service they received.

Evidence reviewed at the follow up comprehensive inspection on 10 May 2017 identified no change to this rating.

Summary of findings

- Data from the national GP patient survey from July 2016 showed patients rated the practice at a comparable level to other practices in the locality.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice did not provide a hearing loop. Patients who were unable to speak English were advised to bring in a family member into their appointment to provide translation services. However the practice nurse confirmed there was a translation service available.
- GPs were unable to show us a recorded care plan. We were told care plans were no longer recorded for unplanned admission to hospital or following discharge from hospitals.
- A carer's list of patients was maintained.
- Feedback from CQC patient comment cards was positive.

Are services responsive to people's needs?

Requires improvement

The practice is rated as good for providing responsive services. At our previous inspection on 26 November 2015 we rated the practice as good for providing responsive services.

Evidence reviewed at the follow up comprehensive inspection on 10 May 2017 identified some areas requiring improvement.

- Feedback from patients reported that there was frequently a wait up to two weeks for a routine appointment, although urgent appointments were usually available the same day.
- The practice was equipped to treat patients and meet their needs. However the surgery building and equipment were showing evidence of wear and tear. There was no maintenance or refurbishment plan in place.
- The complaints procedure was not up dated with the names of key personnel responsible for and managing complaints. Systems to allow patients to complain proactively needed improving as the complaint procedure was provided upon request from the practice manager and records of verbal complaints were not maintained.

Are services well-led?

Inadequate

At our previous inspection on the 26 November 2015 we rated the practice as requires improvement, with key questions Safe, Effective and Well Led rated as requires improvement. The governance arrangements were not fully embedded and this had led to gaps in

Summary of findings

the safe management of the service. For example, staff did not have access to job descriptions and the policies and procedures were not always reviewed on time. There were gaps in recruitment checks, infection control audits, clinical auditing and building checks.

Although some of these arrangements had improved when we undertook a follow up inspection on 10 May 2017, we found other areas of significant concern. The practice is rated as inadequate for being well-led.

- The GP partners were the practice owners and provided clinical care
- Governance arrangements to monitor the provision of safe services to patients were not in place. Gaps in monitoring included lack of oversight of patients on the safeguarding registers and lack of regular and timely medicine reviews and health care checks.
- Systems to monitor and check many aspects of the service were not established or were not effective.
- Policies and procedures although available had not been effectively reviewed to ensure they were relevant to the practice and the services it provided.
- The practice team was small and there was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues on a day to day basis and felt confident and supported in doing so.
- A patient reference group (PRG) or patient forum was established, and evidence that they were consulted on occasion was available.

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 is rated as inadequate for three key questions safe, effective and well-led and requires improvement for providing responsive services and rated good for caring services. The concerns identified overall affected all patients including this population group.

- Staff had received training in safeguarding vulnerable adults and recognised signs of abuse in older patients and knew how to escalate any concerns. However up to date and relevant policies and contact numbers were not available and the GPs confirmed they did not maintain a record of adult patients who could be considered at risk of abuse.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Regular in house clinical meetings were held to discuss patients nearing the end of life in order to ensure their needs were being met.

People with long term conditions

Inadequate

The provider is rated as inadequate for three key questions safe, effective and well-led and requires improvement for providing responsive services and rated good for caring services. The concerns identified overall affected all patients including this population group.

- The practice nurse had lead roles in long-term disease management.
- Data from 2015/16 indicated the practice's performance was similar to local and national averages when monitoring and supporting patients with diabetes. For example the percentage of diabetic patients with a blood pressure reading 140/80mmHG or less recorded within the preceding 12 months was 89%, which was higher than the CCG and England average of 78%. The practice had a higher rate of exception reporting at 16% compared to the CCG average of 11% and the England average 9%.(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).

Summary of findings

- The percentage of diabetic patients whose last measured total cholesterol was 5mmol/l or less within the preceding 12 months was 77%, which was lower than the CCG average of 84%, and the England average of 80%. The practice's and the CCG exception reporting was similar at 15% and 14% respectively, both of which were slightly above the England average 13%.
- The practice nurse confirmed that patients with asthma and chronic obstructive airways disease were provided with a care and treatment plan.

Families, children and young people

Inadequate

The provider is rated as inadequate for three key questions safe, effective and well-led and requires improvement for providing responsive services and rated good for caring services. The concerns identified overall affected all patients including this population group.

- There was a lack of oversight and awareness of children and young people living in disadvantaged circumstances and who were at risk. Registers to provide an overview and to monitor these children were not available.
- Immunisation rates for the vaccines given to children were comparable to the CCG and national averages.
- Quality and Outcome Framework (QOF) 2015/16 data showed 69% of patients with asthma, on the register had an asthma review in the preceding 12 months compared to the CCG average of 77% and the England average of 75%. The practice had a higher rate of exception reporting at 22% compared to the CCG average of 10% and the England average 8%. The practice nurse confirmed they really struggled to get this group of patients to attend the practice for a review.
- The practice's uptake for the cervical screening programme was 76%, which was lower than the CCG average and the national average of 82%. However the practice's clinical exception reporting rate was also lower at 2% compared to the CCG average of 7%.
- The practice was participating in the East Lancs General Practice Quality Framework and one of the initiatives was to target 25 year olds to attend cytology smear appointments. One staff member was the designated cancer champion and was training to develop and roll out the system to call in these young women.
- The practice had emergency processes for acutely ill children and young people.

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Working age people (including those recently retired and students)

Inadequate

The provider is rated as inadequate for three key questions safe, effective and well-led and requires improvement for providing responsive services and rated good for caring services. The concerns identified overall affected all patients including this population group.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours were available and were offered on Tuesday evenings and Thursday mornings.
- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The provider is rated as inadequate for three key questions safe, effective and well-led and requires improvement for providing responsive services and rated good for caring services. The concerns identified overall affected all patients including this population group.

- Systems to identify and follow up vulnerable adults identified at risk of abuse were not maintained by the practice. GPs confirmed that these patients were not coded within the patient record system.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked as required with other health care professionals in the case management of vulnerable patients. This included providing and supporting a substance misuse clinic.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider is rated as inadequate for three key questions safe, effective and well-led and requires improvement for providing responsive services and rated good for caring services. The concerns identified overall affected all patients including this population group.

Summary of findings

- Patients at risk of dementia were identified and offered an assessment.
- 72% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was lower than the CCG average of 85% and the England average of 84%. However exception reporting was also lower at 3% compared to the local average of 5% and the England average of 7%.
- 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months, which was higher than the CCG average of 88% and the England average of 89%. The practice had a higher exception reporting at 16% compared to the CCG average of 12% and the England average 13%.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

What people who use the practice say

The national GP Patient Survey results were published on 7 July 2016. The results showed the practice was performing similarly to the local and national averages. A total of 287 surveys were sent out, 103 surveys were returned. This was a return rate of 36% and represented just over 2% of the practice's patient list.

- 64% of patients found it easy to get through to this practice by phone, compared to the Clinical Commissioning Group (CCG) average of 72%. The national average was 73%.
- 79% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and the national average of 85%.
- 90% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 78%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received five comment cards, all of which were positive about the standard of care received. Comment cards described the reception staff as being responsive, caring and willing to listen.

We spoke with one patient on the day and one patient the day after the inspection. Both were complimentary about the quality of care they received from the GPs and their comments reflected the information we received from the CQC comment cards.

The practice had a patient reference group (PRG) where the practice communicated with patient via email. One patient we spoke with was a member of this group. They told us that they received the occasional email with the outcome of patient surveys.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients
- Ensure patients are protected from abuse and improper treatment
- Ensure there is an effective system for identifying , receiving ,recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

Action the service SHOULD take to improve

- Improve procedures to reflect national good practice in obtaining a written consent before minor surgery is undertaken.
- Strengthen the practice's procedure to safeguard both patients and GPs by recording within the patient record a note of the patients' blood clotting rate (INR), the dose of medicine prescribed and when the next check was due.
- Establish a rolling programme of regular clinical audit and re-audit.
- Develop the practice's patient reference group to provide opportunities for more participation by holding face to face meetings.
- Develop the practice's policy on equality to ensure patients have access to independent interpreting services.

Manchester Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Manchester Road Surgery

Manchester Road Surgery, 187-189 Manchester Road, Burnley, BB11 4HP is part of the NHS East Lancs Clinical Commissioning Group (CCG) and has approximately 4735 patients. The practice provides services under a General Medical Services contract, with NHS England.

Information published by Public Health England rates the level of deprivation within the practice population group as level two on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

The numbers of patients in the different age groups on the GP practice register are generally similar to the average GP practice in England. The practice has 61% of its population with a long-standing health condition, which is higher that the local average of 56% and the England average of 53%. In addition 14% of the practice population are unemployed compared to the CCG average of 5% and the England average of 4%.

The GP practice provides services to patients from a double fronted Victorian property that was originally two separate buildings. There is ramped access available both at the front and rear of the building, although automated opening of doors is not available upon entering the surgery. The practice has two GP consulting rooms and four treatment rooms, which are used by the practice nurse, the two health care assistants and the midwife who attends weekly.

The surgery is open Monday to Friday between 8am and 6.30pm with extensions on Tuesday evenings (open until 7.45pm) and Thursday mornings (open from 6.45am) for pre-bookable appointments. The practice provides a range of on the day, urgent and prebookable routine appointments and there is provision for children to be seen the same day. The practice provides online patient access that allows patients to book appointments and order prescriptions.

The service is led by two GP partners (one male, one female) both provide nine GP consultation sessions each week. They are supported by a practice manager, a full time practice nurse who is also a non medical prescriber, two part time health care assistants as well as an administration team including a deputy practice manager, secretary and reception staff.

The practice is a training practice for year 4 and year 2 medical students.

When the practice is closed patients are asked to contact NHS 111 for Out of Hours GP care.

Why we carried out this inspection

We undertook a comprehensive inspection of Manchester Road Surgery on 26 November 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement overall with key questions safe, effective and well led services receiving this rating.

Detailed findings

We issued four requirement notices to the provider in respect of, safe care and treatment, good governance, staffing and fit and proper persons employed. The practice supplied an action plan which detailed how and when the practice would become compliant with the law by the end of March 2016. We undertook a follow up inspection on 10 May 2017 to check that action had been taken to comply with legal requirements. The full comprehensive report on the November 2015 inspection can be found by selecting the 'all reports' link for Manchester Road Surgery on our website at www.cqc.org.uk.

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 10 May 2017.

During our visit we:

- Spoke with a range of staff including the GP partners, the practice manager, the deputy practice manager, one health care assistant, three receptionists and the practice secretary. We also spoke by telephone with the practice nurse the week after the inspection.
- Spoke with one patient and telephoned one patient the day after the inspection.
- Observed how reception staff communicated with patients.
- Reviewed a sample of patients' personal care or treatment records.
- Reviewed comment cards where patients 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

At our previous inspection on the 26 November 2015 we rated the practice as requires improvement for key question Safe. We found that systems and processes to address some risks were not implemented well enough. For example recruitment checks to were not always carried out, infection control audits were not undertaken and the appropriate building checks were not in place such as gas and electrical safety certificates.

Despite some improvement in the above areas we found other areas of concern at our follow up comprehensive inspection on 10 May 2017. The practice is rated as inadequate for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- 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. Staff confirmed there was an open, safe environment to raise issues. A policy was in place to 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).
- There had been four significant events. For example clinical meeting minutes for March 2017 identified that a patient had been referred by a GP via the two week pathway in October 2016. However the patient did not receive a secondary care appointment. As a result of this, the practice improved their procedures.
- Another significant event recorded in January 2017 identified that the practice had found a patient's blood test result from 2012 which showed the patient to have significantly elevated blood sugars levels. Following the initial blood test the patient was requested to attend the practice but did not attend. The blood result was subsequently identified and discussed with the patient at a substance misuse clinic, almost five years after the initial blood test. As a result of this significant event the practice agreed that all patients with an elevated blood sugar level (HbA1c) of over 80 would have an appointment made.

Overview of safety systems and processes

The practice procedures and processes to minimise risks to patient safety were inadequate

The practice could not demonstrate that the arrangements they had in place for safeguarding reflected relevant legislation and local requirements. Generic and incomplete policies were available. These did not contain the contact telephone numbers for the local safeguarding teams. In addition the practice was unable to demonstrate that they had oversight and knowledge of children and young people with a child protection plan in place or designated at 'risk'. The practice did not maintain safeguarding registers of these patients. Safeguarding registers would assist the active management including, review and monitoring of those children and vulnerable adults assessed at risk from abuse. One GP was not aware of any children on the safeguarding register and the second GP managed to show us one patient flagged on the patient electronic record. Both GPs confirmed that vulnerable adults were not coded within the patient electronic system, so these patients at potential risk of abuse were not identified.

- The GP partners shared joint lead for safeguarding. GPs were trained to child protection or child safeguarding level three. The practice nurse and health care assistant were trained to safeguarding level two.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and since the last inspection in November 2015 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).

The practice maintained standards of cleanliness and hygiene.

- We observed the premises to be clean, although due to the age of the property some areas showed clear evidence of wear and tear. The practice employed a cleaner who worked two hours each day at the practice. This employee had not received any in house training for health and safety including fire safety and infection

control. In addition a lone worker policy and a risk assessment were not available. (The practice provided a lone worker policy the day after the inspection.) However since the last inspection risk assessments for the control of substances hazardous to health were available. A cleaning schedule was available but recorded checks on the cleaning undertaken were not available

- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams and had undertaken recent training. A recent IPC audit and risk assessment had been undertaken and several areas requiring improvement had been identified, including carpet in the GP consultation rooms. The practice manager confirmed that an action plan to implement improvements and mitigate the identified risks had not been developed. The infection control audit from the previous year also identified areas of risk and evidence that action had been implemented following this was not available.
- A number of areas within the practice premises showed clear evidence of wear and tear, including broken worktop seals and seals between the floor and walls in treatment areas. This meant that the practice could not be assured that all areas were cleaned effectively to minimise risk of infection prevention and control. The practice manager confirmed that a maintenance programme or refurbishment plan was not available.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised some of the risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- The processes for handling repeat prescriptions which included the review of high risk medicines were not consistently managed to a safe standard. A review of a sample of 13 signed prescriptions waiting to be collected from the surgery identified a number of areas of concern.

For example:

- Three prescriptions did not contain a medicine review date despite these prescriptions including opiates, medicine for attention deficit disorder and medicine to reduce the risk of blood clots by thinning the blood.
- Ten prescriptions had past their medicine review dates, one of which was from 2012, three from 2013, one from 2014, three from 2016 and two from 2017.
- Administration staff confirmed that not all patients prescribed repeat prescriptions had a medicine review date identified and only some prescriptions had a number to limit or restrict continuous issuing. Staff spoken with confirmed these issue numbers were usually ignored. Following our inspection, the practice implemented an action plan to improve this area of medicine management.
- In addition the practice had a shared care protocol for patients prescribed high risk medicines such as disease-modifying anti-rheumatic drugs (DMARDs). The GP practice was responsible for providing prescriptions and carrying out regularly health checks such as blood tests on these patients. However the practice was unable to provide us with information that demonstrated these patients received the appropriate health checks. There was lack of clarity regarding who was ensuring patients received these health checks, as both the practice manager and another staff member directed us to the other. Following our inspection, the practice implemented an action plan to improve this area of medicine management.
- The practice prescribed patients' blood thinning medicines such as Warfarin. Patients were asked to bring in their blood test results which detailed their blood clotting or coagulation level, which assisted GPs in prescribing the correct dose of medicine. A photocopy of the patient blood results were taken and held collectively for all patients receiving this type of medication. However a written record of the blood test result, dosage of medicine and next review date was not recorded or added to the patient electronic record. This would provide a clear audit trail and an additional safeguard for both patients and clinicians. Following our inspection, the practice implemented an action plan to improve this area of medicine management.
- Records showed that regular checks on the pharmaceutical fridge temperature to ensure optimum temperature ranges were maintained for vaccinations were dependent on the practice nurse availability. For example fridge temperature records for April 2017 showed that these were recorded one day only for the first week in April, for three days each week for the

second and third weeks and for five days the last week. This meant that the practice could not assure themselves that vaccines had been maintained within the correct temperature range.
- Repeat prescriptions were signed before being given to patients and there was a reliable process to ensure this occurred.
- Blank prescription forms and pads were securely stored and there were records of the boxes prescription paper entering the practice.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

At the previous inspection, we found that a recruitment policy was not available and there were gaps in the staff recruitment files we reviewed. At this inspection, a recruitment policy was available. We reviewed three personnel files and one record for a locum GP. We noted improvements including DBS checks, proof of identification, references, qualifications, and registrations with the appropriate professional body.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety. Action had been taken since the previous inspection to improve the health and safety of the building and equipment however significant gaps were identified at this inspection.

- There was a health and safety policy available and poster in reception. The practice manager confirmed they were a fire marshal but had not yet had specific fire safety training for this role. This was identified at the previous inspection in November 2015. The GP partners and the practice cleaner had not had training for fire safety.
- The practice risk assessment for the safe storage and use of liquid nitrogen was incomplete in that it did not identify the potential hazards and risks associated with using and storing this substance.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. Gas and electrical safety certificates were available.
- The practice had annual checks undertaken on the quality and safety of the piped and standing water outlets to assess the Legionella risk (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- At the previous inspection we found some single use equipment such as blood bottles and urinalysis test strips had past their use by date. This inspection identified that all single use equipment we checked was within their expiry date.
- There were arrangements for planning and monitoring the number of staff on duty. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements 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.
- 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 available.
- Emergency medicines were 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 a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on the 26 November 2015 we rated the practice as requires improvement, for key question Effective. We found that there was little evidence that audit was driving improvement in performance to improve patient outcomes and appraisals were not monitored and not all staff had completed their yearly appraisal.

Some arrangements had partially improved when we undertook a follow up comprehensive inspection on 10 May 2017. However, other gaps in service provision were identified. The practice is now rated inadequate for providing effective services.

Effective needs assessment

Clinicians were aware of how to access relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- GPs told us that they were not signed up to get up dates from NICE but accessed the NICE website to get these. We heard that the CCG pharmacist advised GPs and the practice nurse of relevant updates from the Medicines & Healthcare products Regulatory Agency (MHRA).

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 (2015/16) results were 97% of the total number of points available which reflected the average for the clinical commissioning group (CCG) and was slightly higher than the national average of 95%. However clinical exception reporting was overall much higher at 16% compared to the CCG average of 12% and the national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

The practice manager and reception team stated that patients who required an annual review were invited by telephone, text or letter in total three times and if they did not respond they were exempted from the QOF. The practice nurse confirmed that they did struggle to get patients to attend for their chronic disease reviews and that some months between 130 and 140 patients did not attend booked appointments.

Unverified QOF data supplied by the practice had achieved 95% of the total points available for 2016/17.

Data from 2015/16 showed:

- The percentage of patients with diabetes on the register in whom the last blood test (HbA1c) was 64 mmol/mol or less in the preceding 12 months was 76%, compared to the CCG average of 81% and the England average of 78%. The practice also had a high rate of exception reporting at 16% similar to the CCG average of 17% but higher than the England average of 13%.
- The percentage of diabetic patients with a blood pressure reading 140/80mmHG or less recorded within the preceding 12 months was 89%, which was higher than the CCG and England average of 78%. The practice had a higher rate of exception reporting at 16% compared to the CCG average of 11% and the England average 9%.
- The percentage of diabetic patients whose last measured total cholesterol was 5mmol/l or less within the preceding 12 months was 77%, which was lower than the CCG average of 84%, and the England average of 80%. The practice's and the CCG exception reporting was similar at 15% and 14% respectively, both of which were slightly above the England average 13%.
- 92% of patients with diabetes registered at the practice received a diabetic foot check compared with the CCG average of 90% and the England average of 88%. The practice had a higher rate of exception reporting at 19% compared to the CCG average of 12% and the England average of 9%.

Other data from 2015/16 showed the practice performance was similar to or slightly below the local and England averages. For example:

- 82% of patients with hypertension had their blood pressure measured as less than 150/90 mmHg in the preceding 12 months compared to the CCG average of 84% and the England average of 83%. The practice also had a higher rate of exception reporting at 6% compared to the CCG average of 4% and the England average of 4%.

Inadequate

Are services effective?

(for example, treatment is effective)

- 69% of patients with asthma, on the register had an asthma review in the preceding 12 months compared to the CCG average of 77% and the England average of 75%. The practice had a higher rate of exception reporting at 22% compared to the CCG average of 10% and the England average 8%.
- 72% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was lower than the CCG average of 85% and the England average of 84%. However exception reporting was also lower at 3% compared to the local average of 5% and the England average of 7%. (When asked, the GP was unable to show us a care plan).
- 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months, which was higher than the CCG average of 88% and the England average of 89%. The practice had a had higher exception reporting at 16% compared to the CCG average of 12% and the England average 13%. (When asked, the GP was unable to show us a care plan).

There was evidence of some clinical auditing although a rolling programme of regular clinical audit and re-audit was not established.

Since the last inspection in November 2015 a further audit of minor surgery had been undertaken to identify any patients that might have developed an infection. A two cycle audit had been completed for subdermal implants. The second cycle audit identified improvements in the areas previously identified as not meeting the identified criteria. A third first cycle audit of patients with atrial fibrillation (irregular heart beat) had been undertaken in February 2017.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had a stable staff team. An induction programme for all newly appointed staff was available and this covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice nurse confirmed the practice was very supportive in supporting them with training and development. They had just started the Well Woman diploma. Evidence available demonstrated they were up to date with role specific training which included immunisations and vaccinations and cytology. The nurse was a non medical prescriber and ensured they maintained current with attendance at monthly nurse forums and established links with the CCG pharmacist.
- Since the previous inspection staff had had appraisal and they confirmed that they had attended a range of training courses including on line learning.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Both GP partners and the practice cleaner had not received health and safety training including fire safety and infection control.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. However we noted some areas requiring immediate action to ensure patient care needs were met in a timely and appropriate manner. For example:

- One younger patient prescribed a medicine to help with an attention deficit disorder was prescribed a medicine that required three monthly monitoring of height, weight, pulse and blood pressure. The patient's records showed that there were no recordings of height, weight or pulse and only one blood pressure reading from July 2016. The records showed that the patient had not attended hospital appointments on a number of occasions but there was no evidence that the practice had followed this up.
- Another patient's record contained a letter from a secondary care clinic dated September 2016. This requested that the practice prescribe for the patient a medicine for an attention deficit disorder and undertake three monthly blood pressure checks and six monthly weights. There were no records of blood pressure, weight, height or pulse readings.
- Another patients records showed they were prescribed medicine for high blood pressure and an underactive thyroid however the last recorded check in the patient's records for blood pressure was October 2015 and the last blood tests to monitor thyroxine levels were April 2015.

Inadequate

Are services effective?

(for example, treatment is effective)

- Records showed one patient was prescribed a medicine for high blood pressure but the patient's records did not identify or code this patient as having high blood pressure. The last recorded blood pressure reading was in September 2014.

Following our inspection, the practice implemented an action plan to improve the areas identified above and the patients were contacted so that the appropriate health care checks could be undertaken.

- In addition, following a recent significant event incident the practice had changed their protocol to ensure that GPs 'tasked' the administration team to refer patients onto the two week referral pathway to secondary care. The administration team then tasked the GP to confirm this activity had been completed. However staff confirmed that collective monitoring or overview of patients referred on the two week referral pathway to secondary care was not undertaken. This potentially meant that the practice would not be aware if a patient did not receive an appointment within the required timescale.

The practice held monthly clinical meetings to which the palliative care, district nurses, health visitors and midwives were invited. However we heard that these external health care professionals rarely attended the meetings.

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. A policy on consent was available and this referred to the Mental Capacity Act. However the GPs confirmed that they did not require patients to provide written consent before minor surgery was carried out.
- Staff spoken with demonstrated an understanding about patients' capacity to consent to treatment and provided examples where they had assessed a patients' understanding of the treatment offered.

Supporting patients to live healthier lives

Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking were either supported by the practice or signposted to the relevant service.

The practice's uptake for the cervical screening programme was 76%, which was lower than the CCG average and the national average of 82%. However the practice's clinical exception reporting rate was also lower at 2% compared to the CCG average of 7%. There was a policy to offer, text, telephone or written reminders for patients who did not attend for their cervical screening test. The practice nurse confirmed that they struggled to get patients to attend for this screening but felt the text reminder service had improved patient attendance. There were failsafe systems 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 referred its patients to attend national screening programmes for bowel and breast cancer screening. The practice patient uptake of these tests was similar to the CCG and national average. For example data from 2015/16 showed that 73% of females aged between 50 and 70 years of age were screened for breast cancer in the last 36 months was 73% compared the CCG average of 71% and the England average of 73%. Data showed screening for bowel cancer was slightly lower at the practice with a rate of 54% for people screened within the last 30 months compared to 58% for the CCG and the England averages.

One staff member was designated a cancer champion and was working with the CCG on a new initiative to improve cancer screening in the locality. The initial target was to encourage 25 year old females to attend their first cervical smear test and later targets included improving bowel cancer screening.

Data available for childhood immunisation rates for the vaccinations given in 2015/16 indicated that the practice was achieving above 90% or more in the three out of the four indicators.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the MMR1 (measles, mumps and rubella) vaccines given to five year olds was 97%; the CCG's rate was 96% and the England average 94%. MRR2 rates 86%, 76% and 88% respectively.

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.

Good

Are services caring?

Our findings

At our previous inspection on 26 November 2015 we rated the practice as good for providing caring services as data showed patients were generally satisfied with the service they received.

Evidence identified at the follow up comprehensive inspection on 10 May identified no change to this rating.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

A total of five patient Care Quality Commission comment cards were received and these were positive about the service they received. One person commented that getting a routine appointment was difficult. Patients said they felt the practice offered a good service.

We spoke with two patients including one member of the virtual patient participation group, or the patient reference group (PRG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. However they said that getting through to the practice on the telephone first thing in the morning was difficult and usually all the available appointment had gone by the time they got through.

Results from the national GP patient survey (July 2016) showed patients felt they were treated with compassion, dignity and respect. The practice scores were similar to the local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and national average of 89%.
- 87% of patients said the GP gave them enough time which reflected the CCG and national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw which reflected the CCG average and national average.
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and the national average of 85%.
- 88% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 91%.
- 94% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

The two patients we spoke with confirmed they were 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 decisions. Patient feedback from the comment cards we received was also positive and aligned with these views.

GPs were unable to show us an example of a patient care plan. One GP stated that patients with dementia had care plans in place, however the patient record we reviewed did not contain a recorded care plan and following discussion with the GP it was identified that a care plan template was not available.

We heard that children and young people were treated in an age-appropriate way and recognised as individuals.

Good

Are services caring?

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. Scores were slightly higher than local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments. This reflected the CCG and national average score.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 81% and the national average of 82%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 85%.

It was unclear what facilities were provided to assist patients with communication issues to be involved in decisions with their care.

- For example, one GP and other members of the staff told us the practice did not have aces to a language translation service. We heard that patients who were unable to speak English were advised to bring a family member into their appointment to help with translation. This does not reflect NHS England's guidance and principles for providing high quality interpretation and translation services. However the practice nurse confirmed that a telephone language translation service was available.
- The practice did not provide a hearing loop.
- Information leaflets were available on a range of health care issues in the practice waiting rooms.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

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 manager confirmed that they had a register of 69 patients (just under 1.5% of the patient population) who were also carers. The practice's computer system alerted GPs if a patient was also a carer. The practice signposted these patients to avenues of additional support.

Staff told us that if families had experienced bereavement, their usual GP sent them a condolence letter. Patients were offered a 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 our previous inspection on 26 November 2015 we rated the practice as good for providing responsive services

Evidence reviewed at the follow up comprehensive inspection on 10 May identified some gaps in the service provided. The practice is rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Tuesday evenings until 7.45pm and Thursday mornings from 6.45am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability or complex health care need.
- 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 required same day consultation. The practice offered on the day access to patients who arrived at the practice first thing in the morning. One patient told us that this meant waiting though sometimes up to two hours.
- The practice sent text message reminders for appointments.
- The practice offered minor operations, long-acting reversible contraception such as coils and implants, support with substance misuse and medical and DNA testing to patients registered with other practices. In addition the practice was part of the East Lancs federation of GPs and had become the host GP surgery for the new community phlebotomy service in Burnley.
- Patients were able to receive travel vaccines available on the NHS.
- To support patients with disabilities the practice offered ramped access at both the front and rear of the building, although automated opening of doors were not available upon entering the surgery. The practice manager confirmed that assistance was offered to patients that required assistance with opening doors.
- There was confusion around whether the practice offered a language translation service.

Access to the service

The surgery was open Monday to Friday between 8am and 6.30pm with extensions on Tuesday evenings and Thursday mornings for pre-bookable appointments. The practice provided a range of on the day, urgent and pre-bookable routine appointments and there was provision for children to be seen the same day. In addition the practice offered on the day access to patients that arrived first thing in the morning and home visits were provided daily as required. One of the five comment cards we received stated that getting a routine of follow up appointment was difficult.

The practice provided online patient access that allowed patients to book appointments and order prescriptions. The practice told us that they were hoping to encourage more patients to use the online services.

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

- 87% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 64% of patients said they could get through easily to the practice by phone compared with the CCG average of 72% and the national average of 73%.
- 79% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 83% and the national average of 85%.
- 99% of patients said their last appointment was convenient compared with the CCG average of 93% and the national average of 92%.
- 67% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 76% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 58% and the national average of 58%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention. 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 for handling complaints and concerns. The complaints procedure had been updated since the previous inspection to include the details of the Parliamentary and Health service Ombudsman. However the procedure was incomplete in that the policy did not identify a responsible person or a complaints manager. The practice policy stated that leaflets containing sufficient details for people to make a complaint were available in reception and on the practice website. This did not reflect the actual procedure undertaken in that the practice required patients to speak with the manager if they wished to complain.

The practice's complaints log listed two complaints, one from 2015 and one from 2016. The records for the complaint from January 2016 showed the practice had provided a comprehensive response to the complainant.

We heard that one of the GP partners had received a written complaint more recently. However the practice manager was not aware of the details regarding this and was therefore unable to include it on the complaints log and respond to it in a consistent manner in accordance with policy and complaints legislation.

The practice did not log or record patient's verbal complaints. All staff spoken with who had contact with patients confirmed that patients did raise issues, which were usually around either telephone access or access to appointments. Maintaining a log of patient's verbal concerns and the practice's response to these, would assist the practice to identify themes, learn lessons and improve the quality of service provided. The practice policy stated that verbal complaints would be recorded for the purpose of clinical governance and to identify trends.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on the 26 November 2015 we rated the practice as requires improvement, for key question Well Led. The governance arrangements were not fully embedded and this had led to gaps in the safe management of the service. For example, staff did not have access to job descriptions and the policies and procedures were not always reviewed on time. There were gaps in recruitment checks, infection control audits, clinical auditing and building checks.

Although some of these arrangements had improved when we undertook a follow up inspection on 10 May 2017, we found other areas of significant concern. The practice is rated as inadequate for being well-led.

Vision and strategy

The practice had a statement of purpose which detailed the practice's aims and objectives and these included "We aim to ensure safe and effective services, whilst providing the highest quality of care within the environment." and "We aim to continually improve healthcare through monitoring and auditing". Evidence that the practice had implemented a programme of improvement to achieve these objectives was not available.

The practice manager confirmed that the practice didn't have a business plan although they had presented a plan to NHS England under the vulnerable practice scheme to seek funding to support succession planning for the GPs, and training for the practice manager and the practice nurse. The practice's bid had been successful.

A succession plan for other key members of the staff team was not available.

Governance arrangements

The practice had not improved its governance framework to support the delivery of the strategy and good quality care. Some actions had been undertaken since our last inspection in November 2015. However, this inspection identified other gaps in auditing and monitoring the service which collectively indicated an inadequate monitoring framework.

For example:

- Policies and procedures although available had not been effectively reviewed to ensure they were relevant to the practice and the services it provided. For example safeguarding policies were generic and did not detail contact telephone numbers, the complaints procedure was incomplete and did not reflect the actual practice undertaken to support patients who may wish to complain.
- Governance arrangements to monitor the provision of safe services to patients were not in place. The lack of systems to monitor and review the service provided potentially impacted on the safety and effectiveness of patient care and treatment. For example systems to ensure patients received timely medication reviews and the required health checks were not established or were ineffective.
- Other gaps in the governance arrangements included:
- Systems to audit and monitor patients designated at risk or who had a care plan in place for example for dementia were not established.
- Systematic plans to maintain and improve the practice environment and respond to risks identified in the infection control audit were not established.
- Systems to ensure all staff received health and safety training including fire safety and infection control was not established.
- There was lack of clarity about what services the practice provided to support patients with communication such as translation services.
- Systems of audit to ensure pharmaceutical fridge temperatures were monitored in the absence of the practice nurse were ineffective.

However the small staff team had a clear staffing structure and staff were trained and aware of their own roles and responsibilities.

Leadership and culture

Staff told us the partners were approachable and took the time to listen to all members of staff.

- The practice held and minuted a monthly clinical meeting between the GPs, the practice nurse and practice manager and administrative team meetings were held every two to three months. The practice invited members of the multi-disciplinary team to their monthly meeting but we heard they rarely attended.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and

Are services well-led?

Inadequate

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

supported in doing so. However due to ineffective governance arrangements and the lack of effective systems leadership and practice management appeared chaotic.

- Staff told us they were encouraged to identify opportunities to improve the service. For example the deputy practice manager had devised and blood sample request form that GPs ticked when requesting specific blood tests.
- Staff said they felt respected, valued and supported.

The practice had a Being Open policy and this reflected 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). From the sample of records we viewed including one complaint and one significant event we found that the practice gave affected people reasonable support, truthful information and a verbal and written apology when things went wrong.

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

The practice encouraged and valued feedback from patients, the public and staff.

- The practice had a virtual patient reference group. This was a group of 13 patients who were contacted on occasion by email. We spoke with a member of this group who confirmed they received the occasional contact from the practice and this included copies of the patient survey results. The practice manager stated they were hoping to develop a face to face patient participation group in the future.
- The practice carried out their own annual patient survey. Results from the survey in March 2016 were available and the practice had responded to the patient responses with actions as required. At the time of this inspection another patient survey was underway.
- One of the actions identified in the practice survey for 2016 was that patients would welcome a newsletter. These were produced monthly for a six month period in 2016 and there was one newsletter available for 2017.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was managed.

Continuous improvement

- The practice was working with East Lancs General Practice Quality Framework to improve patient outcomes

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 Family planning services 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:** The registered person did not have systems and processes established and operated effectively to respond and protect service users from abuse or improper treatment. In particular: They had failed to have up to date policies and procedures available for all staff which reflected the local safeguarding contact telephone numbers. They had failed to maintain an overview of children with a child protection plan in place or designation of 'at risk'. In addition the practice did not identify vulnerable adults who were or potentially at risk. Regulation 13 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. In particular: They had failed to update the practice policy to reflect the responsible person and complaints manager. They had failed to implement the policy appropriately as the procedure was not readily accessible to patients and verbal complaints were not logged. Regulation 16 (2)

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. In particular: They had failed to identify and respond to the risks associated with prescribed medicines resulting in the lack of regular health care monitoring. They had failed to ensure the management of medicines, including repeat prescription was safe. They had failed to identify the risks associated with the lack of recorded care plans and the lack of proactive checks to monitor patients referred on the two week pathway They had failed to take action in the response to identified risks associated with infection control and prevention, They had failed to identify and mitigate the risks associated with liquid nitrogen and staff training in fire safety and infection control. Regulation 12 (1)

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

This section is primarily information for the provider

Enforcement actions

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

They had failed to implement systems and processes to assess monitor and improve the quality and safety of services provided at the practice. This included systems to monitor patients' to ensure they received the appropriate and timely health care monitoring as required by the type of medicines prescribed.

There was no clear plan of action to review and respond to gaps in service achievements.

Regulation 17(1)