Dr Alec Yolomoni Kapenda

Quality Report

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Lancashire
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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?	**Inadequate**
Are services well-led?	**Inadequate**

Summary of findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as inadequate overall. (Previous inspection July 2016 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires Improvement

Are services responsive? – Inadequate

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those recently retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

People experiencing poor mental health (including people with dementia) - Inadequate

We carried out an announced comprehensive inspection at Dr Alec Yolomoni Kapenda (Abbey Surgery) on 21 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had failed to implement clear systems to manage risk meaning safety incidents were more likely to happen. When incidents did happen, the practice was unable to demonstrate how it learned from them or improved processes.
- Care and treatment were not consistently delivered in line with evidence based best practice guidelines.
- Patient consultation records were not appropriately maintained.
- The practice lacked adequate leadership capacity.
- Governance structures were not sufficient to ensure safe and effective care was offered. There were gaps in practice policies and procedures to govern key activities.
- The practice had failed to review the effectiveness and appropriateness of the care it provided.
- Medicines were not managed in a safe way according to guidance. We saw evidence that some patients were prescribed medicine without appropriate medication reviews and health checks being completed.

Summary of findings

- Staff treated patients with compassion, kindness, dignity and respect during face to face interactions.
- Patients were universally positive about access to the service and told us they found the appointment system easy to use. They were able to access care when they needed it.
- There were gaps in the practice's approach to managing and responding to patient complaints.
- There was a lack of managerial oversight of staff training and we found some gaps in the mandatory and role specific training completed by clinicians.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- 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.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

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

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

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

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

Summary of findings

The six population groups and what we found

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

Older people	**Inadequate**
People with long term conditions	**Inadequate**
Families, children and young people	**Inadequate**
Working age people (including those recently retired and students)	**Inadequate**
People whose circumstances may make them vulnerable	**Inadequate**
People experiencing poor mental health (including people with dementia)	**Inadequate**

Dr Alec Yolomoni Kapenda

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser.

Background to Dr Alec Yolomoni Kapenda

Dr Alec Yolomoni Kapenda (Abbey Surgery, 60 Abbey Street, Accrington, Lancashire, BB5 1EE) provides primary health care services to 1597 patients in the industrial town of Accrington, East Lancashire under a General Medical Services (GMS) contract with NHS England. The practice is part of the East Lancashire Clinical Commissioning Group (CCG). The practice has experienced a recent growth in its patient list size due to a neighbouring practice closing.

Dr Kapenda is a sole GP provider and works with a small team, this includes a practice nurse who is also the practice manager and a support team of four administration staff. The building is a converted residential property and comprises a reception and waiting area downstairs with a storage room and consulting room. There is a patient toilet and baby change facility on the ground floor. Upstairs is a nurse treatment room, an office and a meeting room.

The practice is open Monday to Friday 8am until 6.30pm. Appointments are available throughout the day, from 9.30am until 5.30pm, apart from Tuesday evenings when extended hours are available until 7.15pm, and Thursday afternoons, when pre-bookable appointments with the GP are not available.

The average life expectancy of the practice population is below the national average but in line with CCG averages for females and below both the local and national averages for males (81 years for females, compared to CCG average of 81 years and national average of 83 years. For males; 76 years compared to CCG average of 77 years and national average of 79 years). The practice patient population contains a higher proportion of younger people when compared to local and national averages. For example, 27% aged under 18 years (CCG average 23% and national average 21%). Conversely, only 10% of the practice's patient population are aged over 65 years, compared to the CCG average of 18% and national average of 17%. The practice caters for a lower proportion of patients with a long standing health condition (46% compared to the CCG average of 56% and national average of 54%).

Information published by Public Health England rates the level of deprivation within the practice population as two on a scale of one to 10 (level one represents the highest levels of deprivation and level 10 the lowest). East Lancashire generally has a higher prevalence of Chronic Obstructive Pulmonary Disease (COPD, a disease of the lungs), smoking and smoking related ill-health, cancer, mental health and dementia than national averages.

Outside normal surgery hours, patients are advised to contact the out of hour's service, offered locally by the provider East Lancashire Medical Services.

Inadequate

Are services safe?

Our findings

We rated the practice, and all of the population groups, as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because we were not assured treatment was being delivered in a safe way. Documentation of clinical records was inadequate and there were significant gaps in risk management.

Safety systems and processes

The practice did not have clear systems to keep patients safe and safeguarded from abuse.

- The practice had a suite of safety policies including adult and child safeguarding policies which were communicated to staff and included contact details should further guidance be required or if concerns raised about a vulnerable patient indicated an onward referral was necessary. Staff received safety information for the practice as part of their refresher training.
- The GP could not demonstrate to us that there was system to highlight vulnerable patients on records and a risk register of vulnerable patients. The GP told us alerts were used on patient records to flag up patients at risk of harm, however no examples could be found to illustrate this.
- The practice met with health visitors when asked to do so in order to support patients and protect them from neglect and abuse.
- Non-clinical staff received up-to-date safeguarding and safety training appropriate to their role. However, while the GP and practice nurse told us they had completed safeguarding training, they were not able to show us certificates to confirm this. We were only able to view a safeguarding adults training certificate for the nurse. They knew how to identify and report concerns.
- Reception staff confirmed that the practice nurse would primarily act as chaperone, but they would also carry out this role on the occasions when the nurse was not available. One of the two receptionists we spoke with had completed chaperone training. There was no evidence available to confirm other non-clinical staff had completed such training. We saw evidence that one member of non-clinical staff had undergone 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). This had been completed in 2015 by their previous employer. The practice manager/ practice nurse confirmed to us that no other staff, including the nurse, had a DBS check completed. The practice's safeguarding children policy stated that both receptionists and nurses would have DBS checks completed.
- The practice had not employed new staff or used locum GPs for a number of years, so it was not possible for us to undertake an assessment of current recruitment processes. The practice had an agreement in place with another local GP practice to provide cover when the GP was absent. A recruitment policy was available; this detailed appropriate pre-employment checks the practice would undertake, but did make reference to the Independent Safeguarding Authority (an organisation which ceased to exist in 2012).
- The system to manage infection prevention and control was not effective. The practice nurse was the infection prevention and control (IPC) lead. During the inspection we asked to view the most recent IPC audit completed. The practice nurse told us that an audit was due to be completed, and was unable to locate the most recent once carried out. After the inspection visit the practice sent us a copy of an IPC audit, although it was unclear when this had been completed. At the foot of the audit document there was a note indicating that the premise's bath taps were turned on for a few minutes each week. This note was dated 12 October 2017. The IPC document did not include an action plan or document that action had been taken when issues had been identified, for example the fact that bins were not pedal operated.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However, systems around this were not thorough; the practice understood that portable appliance testing (PAT) was completed on an annual basis when in fact it was last carried out in February 2015.

Inadequate

Are services safe?

Risks to patients

There were not adequate systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff worked flexibly to manage occasions when their colleagues were unable to attend work and should they need to respond to epidemics, sickness, holidays and busy periods.
- Temporary or locum staff were not used by the practice, and there had been no recent recruitment activity undertaken, so it was not possible for us to effectively assess any induction support the practice would offer new staff.
- The practice was not adequately equipped to deal with medical emergencies; while emergency medical equipment was available we saw that the oxygen cylinder in the GP's consultation room was marked as expiring in 1999. There was a second oxygen cylinder in the treatment room which had no expiry date. The practice had a defibrillator on site, but we found a set of defibrillator pads which had expired in 2012. Training certificates were not available during the inspection to evidence the GP and practice nurse had completed basic life support training. After the inspection the practice provided certificates indicating that anaphylaxis e-learning training had been completed by both six days following the visit. These certificates did not reference the inclusion of basic life support training.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention; they were able to describe how patients had been appropriately managed when becoming acutely ill while in attendance at the practice. However, the GP lacked confidence when we asked about identifying and managing patients with severe infections including sepsis and the practice did not have a paediatric pulse oximeter.
- We asked the practice to provide evidence that appropriate indemnity insurance cover was in place. The practice provided renewal reminder correspondence from insurance providers which confirmed that direct debit payments were set up at the time of the letters (July 2016 for the practice nurse, and September 2017 for the GP). However, no confirmation has been received that the indemnity had been renewed.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not written and managed in a way that kept patients safe. We reviewed 10 patient records and in all cases identified gaps in clinical record keeping, for example a lack of detail in consultation notes, including a lack of consistency coding diagnoses.
- The practice lacked adequate systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was no documented approach to the management of test results; the GP told us the nurse reviewed any results returned from pathology. The nurse had received only informal training internally from the practice for this role, and there was no ongoing audit or peer review of decisions made. We found eight examples where abnormal test results had been received by the practice; these had been marked as requiring the patient to see the GP but this had not happened.
- Systems in place for the management of incoming correspondence presented risk. Reception staff confirmed that they triaged incoming correspondence, with some for example DNA (did not attend) letters from secondary care being filed straight into the patient record, without the clinicians having sight of them. Receptionists were not aware of any documented protocol in place to govern this activity, and there was no audit process undertaken by clinicians in order to assure themselves they had sight of everything they needed to. After the inspection the practice provided a 'handling patient information and scanning protocol' dated as reviewed in March 2018. However, this protocol did not match the process described to us during the inspection. For example, it indicated that all documents were sent to the GP to view. It also stated the GP would then return the correspondence to administration staff for them to code on the electronic system. Staff told us during the inspection that this coding was completed by the GP.

Inadequate

Are services safe?

- We found examples where no action had been taken by the practice on receipt of hospital discharge letters requesting patients' medication be updated and where onward referrals had not been made in a timely manner.
- When urgent two week-wait referrals were made, these were logged in the practice's referral book along with all other referrals. Staff found it difficult to articulate the system for checking whether these patients had been offered and subsequently attended an appointment in secondary care.

Safe and appropriate use of medicines

The practice did not have reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment presented risks. The practice held a limited stock of emergency medicines. No risk assessment was documented to record the rationale for not stocking medicine such as benzylpenicillin (used to treat suspected bacterial meningitis).
- The practice could not appropriately demonstrate staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice nurse administered vaccines, but was not qualified as a non-medical prescriber so was required to work to patient group directions (PGDs; these documents govern the use of medicines by qualified staff in order to ensure they are There was a chaotic system in place to ensure these were signed in order to govern the activity appropriately. For example, the PGD for the 2017 flu season had been signed on 19 March 2018. One of the PGDs had not been signed by the nurse. Following the inspection the practice provided pages from a further seven PGDs.
- The practice had reviewed its antibiotic prescribing with the support of the CCG's medicines management team and the GP told us he taken action to support good antimicrobial stewardship in line with local and national guidance. The medicines management team had completed an audit on the practice's antibiotic prescribing, however this audit was not available for us to view during the inspection. The GP was unable to locate the local prescribing guidance to share with us.
- Patients' health was not monitored adequately to ensure medicines were being used safely and followed up on appropriately. The practice did not involve patients in regular reviews of their medicines. We saw three examples in patient records where a medication review had been documented, but where no corresponding documentation of any contact with the patient was recorded as part of these reviews. We saw a further four examples where medicines had been prescribed with a medication review noted as being overdue.
- Prescribing data for the practice for 01/07/2016 to 30/06/2017 showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group was higher than local and in line with national averages; 1.94, compared to 0.65 locally and 0.9 nationally. (This data is used nationally to analyse practice prescribing and Hypnotics are drugs primarily used to induce sleep.)
- Similar data for the prescribing of antibacterial prescription items showed that practice prescribing was slightly above local and national levels; 1.31 compared to 1.00 locally and 0.98 nationally.
- The percentage of antibiotic items prescribed by the practice that were Co-Amoxiclav, Cephalosporins or Quinolones (antibiotics which work against a wide range of disease-causing bacteria) was 6.4%, compared to the local average of 6.4% and national average of 8.9%.

Track record on safety

The practice had worked to improve its safety record since our previous inspection in July 2016, however systems were still not thorough. For example, the practice had documented a fire risk assessment which stipulated a number of mitigating actions, including annual PAT testing of electrical appliances; this testing had not been completed for three years. A legionella risk assessment was documented as completed in July 2016. This risk assessment noted that the practice's boiler was not functional at the time of the assessment. The practice's IPC audit noted that infrequently used water outlets were flushed weekly, however no record of this control regime had been maintained.

Lessons learned and improvements made

Inadequate

Are services safe?

A culture of learning and improvement when things went wrong was not evident in the practice.

- In advance of the inspection, the practice provided four brief summaries of significant event analyses (SEAs) that had been completed in the previous 12 months. These identified limited learning outcomes. During the inspection we discussed these events with the practice manager/nurse, but no documentation relating to them could be located. The GP told us he was aware of one significant event that had occurred in the last year.
- There was no evidence that learning from incidents was shared. Non-clinical staff we spoke to were unaware of any recent SEAs undertaken by the practice.
- The practice could not provide assurance that the system for receiving and acting on safety alerts was thorough. We saw an example of an alert received in January 2018 which required action to complete patient health checks in order to ensure a patient's medication was safe. Despite repeated prompts from the local medicines management team the practice failed to take any action.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice and all of the population groups as inadequate for providing effective services.

The practice was rated as inadequate for providing effective services because we found evidence demonstrating care and treatment was not being delivered in line with evidence-based guidelines and staff could not always evidence the undertaking of appropriate role specific training. Only the practice nurse had received an appraisal in the previous 12 months.

Effective needs assessment, care and treatment

The practice had some systems to keep clinicians up to date with current evidence-based practice. The practice nurse told us she regularly attended training events, and we saw some certificates confirming this, for example around the management of long term conditions such as diabetes and chronic obstructive pulmonary disorder (a disease of the lungs). We saw that up to date NICE guidance was available on the practice computers, although the GP experienced difficulty locating this when asked.

We found evidence that clinicians did not always assess needs and deliver care and treatment in line with current legislation, standards and guidance.

- Consultation records maintained by the practice lacked sufficient detail to provide assurance that patients' immediate and ongoing needs were fully assessed.
- We asked to view the practice's thermometer. Although the practice did have one on site the GP was unable to locate it. The GP told us he did not believe a thermometer to be a useful diagnostic tool.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- We saw no evidence of discrimination when making care and treatment decisions.

We reviewed evidence of practice performance against results from the national Quality and Outcomes Framework (QOF) for 2016/17 and looked at how the practice provided care and treatment for patients (QOF is a system intended to improve the quality of general practice and reward good practice.)

Older people:

- The practice referred patients over the age of 75 years with complex health needs to the over 75 community matron who worked with practices in the locality.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- When older patients were discharged from hospital, the GP told us the discharge summary would be passed to the matron for over 75 year olds who would follow them up to ensure their care and treatment needs were being met.

People with long-term conditions:

- Patients with long-term conditions were not consistently given a structured annual review to check their health needs were being met.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- We were told either the GP or nurse followed up patients who had received treatment in hospital or through out of hours services, however, we found examples in patient records we reviewed where this had not been done.
- Blood measurements for diabetic patients (HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 95% of patients had well controlled blood sugar levels compared with the CCG average of 82% and national average of 80%. However, the practice exception reporting rate for this indicator was 38%, compared to the CCG average of 17% and national average of 12%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).
- We saw that templates were used to populate more comprehensive information in the patient record when reviewing diabetic patients. However, we did find examples where diabetic control was not considered as part of the review.
- The percentage of patients with atrial fibrillation (a heart condition) who were appropriately treated with

anticoagulation drug therapy (to thin the blood) was 75%, compared to the CCG average of 86% and national average of 88%. However, the practice exception reporting rate for this indicator was 43%, compared to the CCG average of 10% and national average of 8%.

- The practice's prevalence of atrial fibrillation was lower than the prevalence across the CCG area (0.74% compared to 1.88%). The practice had identified 10 patients with the condition, but only three were being prescribed warfarin (an anticoagulant medicine).

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the target percentage of 90% for all of the four indicators for vaccinations given to children under the age of two years.
- We were not assured the practice had thorough arrangements for following up failed attendance of children's appointments in secondary care.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 78%, compared to the CCG average of 73% and national average of 72%. The practice had won an award for 2016/17 from public health England for the most improved cervical screening coverage for the 25-49 years age group in the East Lancashire CCG.
- The practices' uptake for breast cancer screening was in line the local and national averages. The percentage of females aged between 50 and 70 screened for breast cancer within six months of invitation was 59%, compared to the CCG average of 61% and national average of 62%.
- However, For example, 34% of patients aged between 60 and 69 had been screened for bowel cancer within six months of invitation, compared to the CCG average of 57% and national average of 54%.
- Patients had access to appropriate health assessments and checks including new patient health checks and NHS checks for patients aged 40-74. In light of the recent influx of new patient registrations, the practice was offering many new patient health checks at the time of inspection, with the practice nurse then prioritising the care and ongoing reviews needed by patients as a result.

People whose circumstances make them vulnerable:

- We saw examples in care records where vulnerable patients attending out of hours settings on multiple occasions over a short period of time had not been followed up by the practice.
- The GP informed us the practice did not have any patients approaching the end of life at the time of our inspection.
- The GP informed us the practice did not have a register of patients living in vulnerable circumstances including those with a learning disability and that annual reviews of their health needs were not routinely offered. However, the nurse told us that when patients with learning disability did attend, they were offered longer appointments.
- The practice worked with the drug and alcohol misuse service to support patients.

People experiencing poor mental health (including people with dementia):

- 75% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months, compared to the CCG average of 88% and national average of 84%.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months, compared to the CCG average of 93% and national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption, compared to the CCG average of 92% and national average of 91%.
- The GP told us that the nurse carried out patients' mental health reviews. The practice nurse confirmed to us that she had not completed any role specific training around mental health.

Inadequate

Are services effective?

(for example, treatment is effective)

- Staff were aware of local charities who offered counselling support for patients with mental health needs.

Monitoring care and treatment

The most recent published QOF results were 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 97%. The overall exception reporting rate for the clinical domains was 14.2% compared with a CCG average of 11.4% and national average of 9.6%.

The practice did not have a comprehensive programme of quality improvement activity and did not routinely review the effectiveness and appropriateness of the care provided. We asked to view any clinical audit undertaken by the practice since out last inspection. While none had been completed or written up, we were shown evidence of an audit that had been commenced around blood measurements and control of blood sugar levels in diabetic patients. We saw that as a result the practice's current year QOF performance for diabetes had improved on the 16/17 results.

Effective staffing

We found in some cases staff did not have the skills, knowledge and experience to carry out their roles. For example, staff whose role included taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. However, the practice nurse administered vaccines but was unable to demonstrate she had attended recent update training for this role. We were shown an email confirming that a place had been booked on a course in September 2017, but no confirmation of attendance was available.

The practice was unable to demonstrate a comprehensive understanding of the learning needs of staff. Up to date records of skills, qualifications and training were not consistently maintained. The practice lacked a systematic approach to completing staff appraisals. We reviewed the personnel files of all staff and found evidence of one receptionist receiving an appraisal in February 2016. Staff confirmed to us they had not had an appraisal. Shortly after the inspection visit the practice provided documentation relating to the practice nurse's appraisal completed in May 2017.

The provider did not ensure the competence of staff employed in advanced roles by audit of their clinical decision making.

Coordinating care and treatment

Staff did not always work effectively with other health and social care professionals to deliver coordinated care and treatment.

- The GP confirmed that the practice did not hold multidisciplinary team meetings to best address and coordinate the care and treatment of patients with complex health needs.
- Evidence indicated patients did not always receive coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- The GP told us how he would ensure that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. However, the practice did not have any patients receiving palliative care at the time of inspection. He gave examples of two recently deceased patients and how the practice had ensured they had passed away in their preferred location.

Helping patients to live healthier lives

Staff worked to help patients live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives and patients at risk of developing a long-term condition.
- The percentage of new cancer cases who were referred under the two-week-wait referral pathway was below local and national averages (29% compared to 54% locally and 52% nationally).
- We saw some evidence that staff encouraged and supported patients to be involved in monitoring and managing their health.
- Consultation records indicated staff did not always discuss changes to care or treatment with patients and their carers as necessary.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice did not consistently obtain consent to care and treatment in line with legislation and guidance.

- The GP did not demonstrate a comprehensive understanding of the requirements of legislation and guidance when considering consent and decision making. The provider had limited knowledge of Gillick competencies and Fraser guidelines.
- We saw one example in patient records where a flu vaccination had been administered with no record of consent.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for caring.

The practice was rated as requires improvement for providing caring services because we were not assured it had an appropriate system for identifying carers and ensuring they had access to appropriate support services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- However, the practice did not consistently give patients timely support and information.
- 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.
- All of the 22 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the feedback given by the two patients of the practice with spoke with on the telephone shortly after the inspection.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 356 surveys were sent out and 79 were returned. This represented a response rate of 22% and was about 5% of the practice population. The practice was generally in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 83% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 90% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 96%.
- 82% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 96% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 98% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care:

- Leaflets were available to staff with instructions around utilising a telephone interpretations service for patients whose first language was not English. However, the leaflet did not include the practice's access code to make use of this service. Staff told us they would contact the CCG to get the code should they need to use the service.
- Staff communicated with patients in a way that they could understand.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice found it difficult to confirm during the inspection the number of patients on its list who were also a carer. Shortly after the visit the practice provided evidence demonstrating it had identified 19 patients as carers (1.2% of the practice list). The practice did not have a proactive approach to identifying and supporting carers. Clinicians told us that they knew their patients well and would ensure any carers they were aware of were called into the practice to be offered a flu vaccination.

Staff told us that if families had experienced bereavement, the practice supported them by giving advice on how to find a support service as necessary.

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 generally in line with local and national averages:

- 84% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 86% and the national average of 86%.

Requires improvement

Are services caring?

- 79% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 81%; national average - 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 95% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 88%; national average - 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Conversations with receptionists could be overheard by patients in the waiting room, but a private room would be found if required.
- We did note that treatment and consultation room doors did not have locks. We observed staff lock their computers when they left their desk.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as inadequate for providing responsive services overall, with the population groups older people, people with long term conditions and people whose circumstances make them vulnerable rated inadequate for this key question. The other population groups were rated as requires improvement for providing responsive services.

The practice was rated as inadequate for providing responsive services because it lacked an appropriate system for identifying and managing patient complaints.

Responding to and meeting people's needs

The practice told us it organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. Extended opening hours were offered on a Tuesday evening and the practice offered online services such as repeat prescription requests and advanced booking of appointments.
- The facilities and premises were appropriate for the services delivered.
- The practice premises had a stair lift to facilitate access to the nurse's treatment room on the first floor for those patients experiencing mobility difficulties. While we saw documentation demonstrating the stair lift had been services, we did not see an appropriate risk assessment relating to its use.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice told us it was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met, although practice exception reporting was high in some cases.
- The practice did not have regular documented contact with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were limited systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group 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 offered.
- The practice did not have a website at the time of inspection, making it difficult for patients to find out about services offered without contacting the practice.

People whose circumstances make them vulnerable:

- The GP told us the practice did not hold a register of patients living in vulnerable circumstances including those with a learning disability.
- However, clinicians told us they knew their patient cohort well and so were able to tailor the services offered accordingly. Patients known to the practice as having enhanced needs were offered open access to ensure they received the support required in a timely manner; that is the practice accepted them coming to see a clinician without prior booking of an appointment. Clinicians worked flexibly to ensure they were seen.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- The practice signposted patients to local charities who offered support such as counselling for patients with mental health needs.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- There was clinical capacity for patients with the most urgent needs to have their care and treatment prioritised, although the sample of patient records we viewed indicated this was not consistently the case.
- Patients were universally positive in their feedback to us about access to the service and reported that the appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 92% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 82% and the national average of 80%.
- 87% of patients who responded said they could get through easily to the practice by phone; CCG – 72%; national average - 71%.
- 81% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 74%; national average - 76%.
- 93% of patients who responded said their last appointment was convenient; CCG - 93%; national average - 81%.
- 96% of patients who responded described their experience of making an appointment as good; CCG - 72%; national average - 73%.
- 75% of patients who responded said they don't normally have to wait too long to be seen; CCG - 75%; national average - 58%.

Listening and learning from concerns and complaints

The practice's system for managing patient complaints was not adequate.

- Information about how to make a complaint or raise concerns was available, although the complaints leaflet available from the reception area did not inform patients of the option to raise a complaint through NHS England. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. One complaint had been received in the last year. We reviewed this complaint dated August 2017 and found that it had not been handled in line with the practice's own documented complaints procedure, which stated receipt of a complaint would be acknowledged within three working days. No documentation of such an acknowledgement was available. The practice sent two responses to the complaint, each responding to a separate element of the concern. These responses included an apology that the patient was dissatisfied, but did not explain what measures the practice would put in place in order to prevent a repeat.
- There was limited evidence the practice learned lessons from individual concerns and complaints in a timely manner. For example, the practice nurse had documented reflections on the complaint received by the practice in August 2017. These reflections were dated 14 February 2018.

Are services well-led?

Inadequate

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

Our findings

We rated the practice and all of the population groups as inadequate for providing a well-led service.

The practice was rated as inadequate for well-led because there was insufficient management capacity and appropriate governance arrangements were not in place to ensure the delivery of safe and effective care.

Leadership capacity and capability

The practice had insufficient leadership capacity and skills to deliver high-quality, sustainable care.

- The practice manager was also employed as the practice nurse. This resulted in such demands being placed on the staff member's time that it resulted in a lack of appropriate managerial oversight over many elements of the running of the practice.
- There was a lack of knowledge around issues and priorities relating to the quality and future of services. There was limited understanding of the challenges and little evidence these were being addressed.
- We identified evidence relating to risk during the inspection, but practice leadership had limited insight into its implications.
- Staff described the provider and practice manager as approachable. Staff appreciated that the practice manager worked flexibly to support non-clinical colleagues during periods of staff absence.

Vision and strategy

The provider articulated a clear vision to increase the size of the practice's patient list in order to generate more income and so be able to invest in increased resources. Emphasis was placed on being as friendly to patients as possible. Staff were aware of and understood the vision, values and their role in achieving them. However, no documented business plans were in place to support the implementation of the vision.

Culture

The practice did not have an embedded culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice and described a strong teamwork ethos.
- The practice staff told us they focused on the needs of patients, however inadequate systems and processes in place meant that this was not always achieved.
- There was limited evidence of openness and transparency when responding to incidents. Shared learning was not inherent in the practice's culture. For example staff were unaware of the four significant events that had been logged. While we saw the practice offered apologies when patients raised complaints, patients were not told what measures were being taken in order to prevent the incident being repeated.
- The practice lacked processes for providing all staff with the development they need. Most staff had not had access to appraisal and career development conversations.
- The nurse was considered a valued member of the practice team. While they were given protected time for professional development (for example attending the CCG's practice nurse forum meetings), the additional responsibilities of the practice management role meant there was a lack of overall capacity and insufficient opportunity for thorough evaluation of their clinical work.
- The practice was aware of the issues around equality and diversity. Some staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

The practice's governance framework was inadequate. There was a lack of clear systems of accountability to support good management.

- Structures, processes and systems to support governance and management were unclear and ineffective.
- Evidence indicated the practice relied on other professionals such as the local medicine's management team and over 75s matron, rather than working in true partnership with them.

Are services well-led?

Inadequate

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

- Staff were not fully clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had failed to establish proper policies, procedures and activities to ensure safety nor had they assured themselves that those that were in place were operating as intended.
- We viewed a number of the practice's policy and procedure documents which were overdue review, for example the chaperone policy recorded as being reviewed in June 2016, with the next review being due in June 2017. Others had not been made practice specific, for example the IPC policy had space to name the CCG lead for IPC, but this had not been populated. The range of policies available at the time of inspection was not adequate to cover the scope of work undertaken by staff, for example staff did not have access to a documented procedure for managing incoming correspondence. We also found a number of examples where practice activity was not aligned to policies that were in place, such as staff not having a DBS check in place despite the safeguarding children policy indicating they would.
- Communication channels within the practice staff team were informal in nature meaning there was no clear audit trail of information relating to changes being disseminated. The practice did not have an embedded meeting structure.

Managing risks, issues and performance

There were gaps in processes for managing risks, issues and performance.

- There were ineffective processes to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice lacked processes to manage current and future performance. Performance of employed clinical staff could not be demonstrated as, for example, the provider had not carried out audit of their consultations and referral decisions. Practice leaders lacked adequate oversight of national and local safety alerts, incidents, and complaints.
- Limited audit activity had been undertaken and the practice did not have an embedded programme of ongoing clinical audit to drive quality improvement and positively impact patient outcomes.
- While the practice had some plans in place and had trained staff for major incidents, suitable emergency equipment was lacking and medicines were missing.

Appropriate and accurate information

The practice was not able to assure us it consistently acted on appropriate and accurate information.

- Some quality and operational information such as QOF was used to ensure and improve performance.
- We did not see evidence that quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice had access to information technology systems to facilitate the monitoring and improvements of the quality of care. However, we were not assured that senior figures in the practice were appropriately proficient in their use to maximise their effectiveness.
- The practice submitted data or notifications to external organisations as required, although the practice disputed the accuracy of some previously published healthcare data, such as childhood immunisation and vaccination rates.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, the lack of lockable consultation and treatment room doors presented risk which had not been adequately assessed.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services. There was an active patient participation group (PPG). We spoke with a member of the group on the telephone who confirmed the PPG of approximately six patients met roughly twice per year to discuss concerns with the practice. The most recent meeting was reportedly

Are services well-led?

Inadequate

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

during the summer of 2017. Previous suggestions from the PPG which the practice had acted on included the removal of toys from the waiting area due to concerns around infection control.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation.

- The practice failed to make use of internal and external reviews of incidents and complaints. Learning was not shared or used to make improvements.
- Time pressure placed on leaders, managers and staff meant there was little scope for them to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 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. For example, we viewed complaint responses which were not in keeping with the practice's own complaints policy, and did not detail to the patient what the practice planned to do to prevent the incident being repeated. Learning from complaints was not identified in a timely manner. This was in breach of regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services 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 provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • There was only a limited range of emergency medicines available at the practice, with no documented risk assessment in place to record the rationale for not stocking others. • Some emergency equipment was out of date. • Staff acting as chaperones had not had DBS checks completed or undertaken suitable training for the role. • Clinicians had not completed appropriate safeguarding training. • We found evidence of abnormal test results being documented in patient's records, with no subsequent action recorded as being taken. • Onward referrals to secondary care had not been completed in a timely manner. • The practice was not routinely following up vulnerable patients who had frequently attended out of hours' care providers. There was insufficient proper and safe management of medicines. In particular: • The practice was not carrying out patient medication reviews in an appropriate or timely manner. There was also evidence the practice had failed to take appropriate action to ensure patients had appropriate medicine.

This section is primarily information for the provider

Enforcement actions

This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular: • Consultation records we viewed lacked sufficient detail. The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. • The system for logging, investigating and sharing learning from significant events was insufficient. • Practice policies were insufficient to cover the scope of work undertaken by practice staff, and many that were in place were overdue review and did not appropriately describe the activities undertaken by the practice. • The IPC audit process was not sufficiently embedded into practice. • The approach to managing patient safety alerts was not thorough. • The practice lacked a systematic approach to the management of PGDs.

This section is primarily information for the provider

Enforcement actions

- The nurse was responsible for managing pathology results, with no clinical oversight of decisions made by the provider.
- The monitoring of urgent two week wait referrals was not thorough.
- Mitigating actions identified in documented risk assessments were not consistently completed.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- We found limited evidence of quality improvement work completed. No clinical audits had been completed.

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:**

The provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- Only the practice nurse had received an appraisal in the previous year.
- The practice nurse was unable to evidence completion of training around IPC, immunisation and vaccination, and management of mental health issues.

This section is primarily information for the provider

Enforcement actions

This was in breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.