College Road Surgery

Quality Report

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Date of inspection visit: 18 February 2016
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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?	Inadequate
Are services responsive to people's needs?	Inadequate
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 College Road Surgery on 18 February 2016. Overall the practice is rated as inadequate.

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, the practice could not demonstrate that all incidents were recorded, that reviews and investigations were thorough enough or that learning was shared effectively with staff.
- Risks to patients were not all assessed or well managed for example no Legionella risk assessment had been completed.
- Data showed patient outcomes were mixed compared to local and national patient outcomes. Evidence was hard to identify as little or no reference was made to audits or quality improvement and there was little evidence that the practice was comparing its performance to others; either locally or nationally.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- Information about services was available but not everybody would be able to understand or access it.
- Urgent appointments were usually available on the day they were requested
- The practice had a number of policies and procedures to govern activity.

The areas where the provider must make improvements are:

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses and ensure that lessons learnt from complaints and significant events are communicated to the appropriate staff to support improvement.

Summary of findings

- Ensure that all building risk assessment and safety checks are completed including gas safety checks and Legionella risk assessments.
- Ensure that the actions identified from risk assessments are completed including infection control and fire safety risk assessments.
- Carry out clinical audits and re-audits to improve patient outcomes and to ensure improvements have been achieved.
- Ensure that a robust system is put in place for acting on correspondence from external sources such as hospitals including pathology results and medicine changes.
- Ensure that emergency equipment including oxygen is stored in an appropriate location that is easily accessible to all staff.
- Ensure that appropriate training is completed including Mental Capacity Act and ensure that all staff understand the relevant consent and decision-making requirements of legislation.
- Ensure that they have done everything reasonably practicable to provide safe care and treatment to patients whose first language is not English due to the practice telling us their population is 86% Urdu speaking who do not have English as their first language.
  - Review the risks of using friends and family to translate and as advocates at times of obtaining consent and providing treatment because of the risk of them biasing the consultation.
- Ensure that patient privacy is maintained at all times including that doors close properly and staff can not be overheard in the waiting room.
- Ensure that disabled facilities are adequate to meet the needs of their patient group.
  - Ensure that the process to register a manager with CQC for this location is completed.

In addition the provider should:

- Improve the availability of non-urgent appointments.
- Provide practice information in appropriate languages and formats.
- Review their exception reporting criteria and practice performance to improve patients outcomes.
- Review and update procedures and guidance.
- Review and improve where possible confidentiality for patients.
- Conduct an up to date fire risk assessment.
- Review the emergency medicines held on site and the management of these.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made so a rating of inadequate remains 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 practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when there were unintended or unexpected safety incidents the practice could not provide evidence in every case that thorough reviews and investigations had taken place or that lessons learned were communicated widely enough to support improvement.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.
- We saw that the oxygen cylinder was being stored above head height.
- The practice could not provide evidence of Mental Capacity Act training for any staff and some clinical staff we spoke did not demonstrate a working knowledge or understanding of this.
- We saw evidence that all clinical staff had completed adult safeguarding training and most non-clinical staff had completed adult and child safeguarding.
- We did not see evidence that a robust system was in place for handling incoming correspondence and pathology results.
- On the day of inspection, when asked, the practice did not provide evidence of building electrical or gas safety checks or Legionella risk assessments (bacterium which can contaminate water systems in buildings). Since the inspection the practice have provided evidence of a current electrical safety inspection report.
- We saw evidence of a fire risk assessment which took place in 2014 but when asked the practice did not provide evidence that all actions identified had been completed. The practice did not provide evidence of a log of fire drills and none of the staff we spoke with could remember an evacuation fire drill. We looked a sample of five training records and we noted that one GP who was in the process of leaving the practice had not completed fire safety training.
- We saw evidence of recent infection control and health and safety audits but when asked the practice did not provide evidence of action plans to address issues raised by the audits.

Summary of findings

Are services effective?

Inadequate

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

- Data showed patient outcomes were comparable to the locality and nationally. However overall exception reporting was 23.6% which was much higher than the clinical commissioning group (CCG) and national averages (CCG 8.8%, national 9.2%). 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.
- There was no evidence that audit was driving improvement in performance to improve patient outcomes and there was little evidence that the practice was comparing its performance to others; either locally or nationally.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

Are services caring?

Inadequate

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

- Data from the National GP Patient Survey showed patients rated the practice lower than others for many aspects of care. For example, 60% of patients said the last GP they spoke with was good at treating them with care and concern (CCG average 84% and national average 85%) and 62% of patients said the last nurse they spoke with was good at treating them with care and concern (CCG average 90% and national average 91%).
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- Information for patients about the services was available but not everybody would be able to understand or access it. For example, there were no information leaflets available in Urdu despite there being a large number of Urdu speaking patients on the practice list.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.

Summary of findings

- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.
- The practice was equipped to treat patients and meet their needs.
- Patients could get information about how to complain however this was only provided in English and there was a high number of Urdu speaking patients on the practice list. There was no evidence that learning from complaints had been shared appropriately with staff.
- The practice had an external review of access for patients in 2015 and provided evidence that they had acted on some of the recommendations to improve access for patients.

Are services well-led?

Inadequate

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

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- The practice had a number of policies and procedures to govern activity but we saw evidence that these were not always followed and some staff we spoke with were unaware of them.
- The practice proactively sought feedback from patients and had an active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for safety, caring, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety, caring, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice:

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice was performing better than the national averages for diabetic indicators. For example, 90% of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months was higher than the national average 78%. However exception reporting was much higher than CCG and national average for five out of the eleven diabetic indicators.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP however, not all these patients had a personalised care plan or structured annual review to check that their health and care needs were being met.

Families, children and young people

Inadequate

The provider was rated as inadequate for safety, caring, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group.

- 73% of patients with asthma, on the register, had an asthma review in the preceding 12 months this was comparable to the national average 75%.

Summary of findings

- Immunisation rates were mixed for standard childhood immunisations with some much lower than CCG average and others comparable to or slightly higher.
- Appointments were available outside of school hours. However, the premises were not ideal for young children and babies. For example the entrance into the downstairs consulting rooms was through two doors in a confined space which was difficult for patients with pushchairs. There were also no baby changing facilities available unless a clinical room was not in use.
- The practice recorded that 69% of women aged 25-64 had a cervical screening test performed in the preceding 5 years (01/04/2014 to 31/03/2015). This was much lower than the national average of 82%.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety, caring, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice:

- The practice offered extended hours appointments two evenings a week until 7.30pm for patients who found it difficult to attend during normal surgery hours.
- The practice offered online services and electronic prescribing service 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 was rated as inadequate for safety, caring, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, some examples of good practice:

- It had carried out annual health checks for people with a learning disability, but there was no evidence that these had been followed up.
- Staff told us they had some pictorial cards that they could use to help communicate with patients.
- Most staff knew how to recognise signs of abuse in vulnerable adults and children.
- Most staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and clinical staff were aware of how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

- The practice when asked did not show us a policy or protocol and staff did not describe arrangements to allow people with no fixed address to register or be seen at the practice, although some members of staff told us they would ask the partners.
- Some clinical staff we spoke with did not demonstrate clear understanding of patient consent.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safety, caring, effective, responsive and well-led. The issues identified as inadequate overall affected all patients including this population group. There were, however, some examples of good practice:

- 100% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average 84%. However the exception reporting rate was 20% which was much higher than the national average exception reporting rate 8.3%.
- 73% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was lower than the national average 88%.
- Clinical staff told us they worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia however when asked they did not provide any documented evidence of this on the day of inspection.
- The practice carried out advance care planning for patients with dementia, and in appropriate cases this was shared with other local services such as the ambulance service.
- Most clinical staff had a good understanding of how to support patients with mental health needs and dementia.
- Staff we spoke with could not describe a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.
- Some staff we spoke with did not demonstrate clear understanding of patient consent.

Summary of findings

What people who use the service say

The national GP patient survey results published January 2016 showed the practice was performing worse than local and national averages. 399 survey forms were distributed and 74 were returned. This represented 2% of the practice's patient list.

- 33% of patients found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group average of 64% and a national average of 73%.
- 58% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 84% and national average 85%).
- 51% of patients described the overall experience of their GP surgery as good (CCG average 82% and national average 85%).
- 38% of patients said they would recommend their GP surgery to someone who has just moved to the local area (CCG average 76% and national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards which were mostly positive about the standard of care received. Patients said that staff were friendly and patient and they received a good service, although there were several comments about difficulties getting appointments with a doctor.

We did not speak with any patients during the inspection.

Areas for improvement

Action the service MUST take to improve

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses and ensure that lessons learnt from complaints and significant events are communicated to the appropriate staff to support improvement.
- Ensure that all building risk assessment and safety checks are completed including gas safety checks and Legionella risk assessments.
- Ensure that the actions identified from risk assessments are completed including infection control and fire safety risk assessments.
- Carry out clinical audits and re-audits to improve patient outcomes and to ensure improvements have been achieved.
- Ensure that a robust system is put in place for acting on correspondence from external sources such as hospitals including pathology results and medicine changes.
- Ensure that emergency equipment including oxygen is stored in an appropriate location that is easily accessible to all staff.
- Ensure that appropriate training is completed including Mental Capacity Act and ensure that all staff understand the relevant consent and decision-making requirements of legislation.
- Ensure that they have done everything reasonably practicable to provide safe care and treatment to patients whose first language is not English due to the practice telling us their population is 86% Urdu speaking who do not have English as their first language.
- Review the risks of using friends and family to translate and as advocates at times of obtaining consent and providing treatment because of the risk of them biasing the consultation.
- Ensure that patient privacy is maintained at all times including that doors close properly and staff can not be overheard in the waiting room.
- Ensure that disabled facilities are adequate to meet the needs of their patient group.
- Ensure that the process to register a manager with CQC for this location is completed.

Action the service SHOULD take to improve

- Improve the availability of non-urgent appointments.

Summary of findings

- Provide practice information in appropriate languages and formats.
- Review their exception reporting criteria and practice performance to improve patients outcomes.
- Review and update procedures and guidance.
- Review and improve where possible confidentiality for patients.
- Conduct an up to date fire risk assessment.
- Review the emergency medicines held on site and the management of these.

College 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 College Road Surgery

College Road Surgery is based in the Maybury area of Woking. The surgery building is a converted residential property. The practice is part of the Glenlyn Medical Centre which consists of three practices in total. College Road Surgery is a small practice and at the time of our inspection there were approximately 3,400 patients on the practice list.

The practice has three doctors and two nurse practitioners. They are supported by a practice nurse, two health care assistants, reception and administration staff and a practice manager.

The practice is open between 8.30am and 6.30pm Monday to Friday. Extended hours appointments are offered between 6.30pm and 7.30pm on a Wednesday and Thursday evening. Patients requiring a GP outside of the normal surgery hours are advised to call NHS 111 where they will be directed to the most appropriate out of hours service.

The practice holds a Personal Medical Services (PMS) contract and offers enhanced services for example various immunisation schemes and admissions avoidance.

The service is provided at the following location:-

College Road Surgery

4-6 College Road

Woking

Surrey

GU22 8BT

The practice population has higher number than average of patients from birth to 39 years, particularly birth to 14 years and 25 to 35 years. The practice has a lower number than average of patients over 40 years. The practice has a slightly lower than average percentage of patients with long standing health conditions and a higher number than average of unemployed patients. The practice area is more deprived than others in the locality; people living in more deprived areas tend to have a greater need for health services.

The CQC (Registration) Regulations 2009 require a GP partnership to have a registered manager, College Road Surgery do not currently have a registered manager.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

Detailed findings

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 18 February 2016. During our visit we:

- Spoke with a range of staff including GPs, nurses, receptionists and the practice manager and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager or clinical lead of any incidents.
- The practice did not always demonstrate a thorough recording or analysis of the significant events and there was little evidence that learning was shared with appropriate staff. Staff we spoke with gave us an example of an incident they had reported but when we asked the practice to provide evidence they did not. Staff also gave us an example of an incident they had been involved in where they felt they had not been asked to contribute to the investigation or had any feedback about it. When we asked the practice they did not provide any evidence of the investigation or shared learning.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. The practice did not provide evidence that learning was shared appropriately to make sure action was taken to improve safety in the practice.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs had not attended safeguarding meetings in the last 12 months but provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and we saw evidence that GPs were trained to Safeguarding children level three. We looked at a sample of training records and saw evidence that these staff had completed adult and child safeguarding.
- 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 had received a Disclosure and Barring Service check (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 appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken however the practice did not provide evidence of an action plan resulting from the audit to ensure that actions were completed in a timely manner.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. We saw large quantities of prescription paper in printers in rooms that were not locked when not in use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- A system has recently been put in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were not fully assessed or well managed.

Inadequate

Are services safe?

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice did not have up to date fire risk assessments. The practice did not provide evidence of a log of fire drills and none of the staff we spoke to could remember an evacuation fire drill. We looked a sample of five training records and saw that one GP had not completed fire safety training.
- All portable electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. However on the day of inspection the practice did not provide evidence of an electrical safety check for the building wiring or a gas safety check. Since the inspection the practice has had a buildings electrical safety check done and we have seen evidence of this.
- The practice did not have risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. However some staff we spoke with told us they did not think there was always sufficient doctor cover.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- We reviewed five staff training records and saw that they had received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and the practice confirmed that all staff had been trained to use it however some non clinical staff we spoke with told us they did not know how to use it.
- The practice had oxygen on site with adult and children's masks. We saw that the oxygen cylinder was being stored above head height staff. This could result in delay in treatment for a patient who required oxygen treatment and injury to staff members. On the day of inspection the practice did not provide evidence of a risk assessment regarding the storage of oxygen. On the day of inspection we brought this to the attention of the practice but observed that the oxygen had been put back above head height at the end of the day.
- A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice however not all staff knew of their location. All the medicines we checked were in date and fit for use. Best practice for practices that fit coils (IUCDs) is to have an emergency medicine on site to treat bradycardia which is a rare but potentially serious side effect. The GP who fitted coils thought that the medicine was on site and was unaware that it wasn't until they showed us the where it should have been stored. The implication of this was that a patient having a coil fitted could be put at risk by the lack of emergency medicine the GP expected to be available.
- The practice had a business continuity plan in place 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

Effective needs assessment

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

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients needs.
- The practice did not monitor that these guidelines were followed. The practice did not provide meeting minutes or other evidence which showed this guidance was discussed or disseminated to appropriate staff. Staff told us they got some information sent to them about changes to local pathways and safety alerts from the clinical lead.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 93% of the total number of points available, with 24% exception reporting, which is much higher than the national average of 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). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed:

- Performance for diabetes related indicators was better than the national average. For example; 91% of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less compared to national average of 78%.
- 86% of patients with hypertension having regular blood pressure tests was similar to the national average 84%.
- Performance for mental health related indicators was better than or comparable to the national average with the exception patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months where the practice results was 73% and the national average was 88%.

The practice told us that they have not carried out any clinical audits in the last year.

- The practice participated in local audits where the clinical commissioning group (CCG) pharmacist attended the practice regularly and carried out prescribing audits. This has resulted in the practices prescribing improving and becoming comparable with other practices; the practice told us that previously they had been very high compared to the rest of the CCG.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those staff reviewing patients with long-term conditions.
- Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Not all staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to training, on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. We looked at the training records of five staff and saw that they had had an appraisal within the last 12 months.
- The practice did not provide evidence that there was a system of clinical supervision or peer review to ensure that staff were acting within their competency.
- Almost all staff had received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to

and made use of e-learning training modules and in-house training. We looked at the training records of five staff and saw that except one GP they had completed fire safety training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available, although only in English.
- The practice shared relevant information with other services in a timely way, for example, when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Staff we spoke with told us that that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. The practice did not provide any documentary evidence of this.

Consent to care and treatment

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

- GPs and the advanced nurse practitioner we spoke with understood the relevant consent and decision-making requirements of legislation and guidance however other staff did not. The practice were not able to provide evidence that any staff including GPs had any formal training with regard to the Mental Capacity Act 2005 and staff we spoke with were not able to demonstrate they understood the requirements of the act.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or advanced nurse practitioner assessed the patient's capacity and recorded the outcome of the assessment. However some clinical staff that we spoke could not demonstrate an understanding of who could give consent. For example they told us they would accept consent from a person accompanying a patient to an appointment without confirming there was written authority for the person to give consent.
- The practice consent policy stated that to confirm a patient who did not speak English was happy for the person accompanying them to have access to their personal medical records the accompanying person should ask them to nod to confirm this.
- The process for seeking consent was not monitored through records audits

Supporting patients to live healthier lives

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

- These included patients in the last 12 months of their lives and carers. Patients were then signposted to the relevant service.

The practice's uptake for the cervical screening programme was 69%, which was worse than the national average of 82%. The practice ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were mixed compared to CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 15% to 85% (CCG average 75% to 88%) and five year olds from 58% to 90% (CCG average 76% to 91%).

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.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were helpful to patients and treated them with dignity and respect, however people's privacy, dignity and confidentiality was not always respected.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard however during our inspection we noted on several occasions were not latched properly and opened unexpectedly during consultations which meant that patients privacy was not maintained at all times.
- We observed that in the waiting room conversations in the reception area including patient information could be overheard.

We received 22 patient Care Quality Commission comment cards and 17 were positive about the service experienced. Patients said they felt the practice offered good service and staff were helpful, caring and friendly. The five comment cards that were not positive included comments about difficulty getting to see a doctor and one complaint about the practice.

On day of inspection we did not speak to any patients.

Results from the national GP patient survey showed the practice was significantly below local and national averages for its satisfaction scores on consultations with GPs and nurses. The results showed that people did not feel cared for and feedback about interactions with staff was negative. The practice management team were aware of the poor survey results and in early 2015 had commissioned an external review of patients access to help address some of the areas of concern. For example:

- 64% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 88% and national average of 89%.
- 63% of patients said the GP gave them enough time (CCG average 85% and national average 87%).
- 83% of patients said they had confidence and trust in the last GP they saw (CCG average 95% and national average 95%).
- 60% of patients said the last GP they spoke with was good at treating them with care and concern (CCG average 84% and national average 85%).
- 62% of patients said the last nurse they spoke with was good at treating them with care and concern (CCG average 90% and national average 91%).
- 56% of patients said they found the receptionists at the practice helpful (CCG average 83% and national average 87%).

Care planning and involvement in decisions about care and treatment

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

- 61% of patients said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 85% and national average of 86%.
- 56% said the last GP they saw was good at involving them in decisions about their care (CCG average 80% and national average 82%).
- 55% said the last nurse they saw was good at involving them in decisions about their care (CCG average 84% and national average 85%).

Due to the language barrier patients do not always know or understand what is going to happen to them during their care. The language barrier and results from the national GP survey show patients are not always involved in their own care or treatment. Patient's preferences and choices were not always heard or acted on due to the language barrier and lack of independent translations.

We observed that some staff were judgmental or dismissive of people using their services or those close to them. Patients basic needs were not always met.

Staff told us that they routinely use friends and family to translate for patients who did not have English as a first language however, translation services were available if required. There is a potential risk to patients when family members and friends are used to translate, this is due to the possibility that the translator does not understand or

translate accurately what the clinician is saying, that they may modify what they tell the patient or the clinician or that the patient may not fully describe the symptoms in order to avoid embarrassment. We did not see any notices informing patients this service was available although we saw notices in the clinical rooms with details of how to contact a telephone translation service which was only in English. There was a non-clinical member of staff who started in January 2016, but was not always on site, who was identified as an Urdu advocate who was fluent in Urdu and could help translate. The practice told us that English was not the first language for 86% of their patient list and that approximately 90% of the population were Urdu speaking.

Patient and carer support to cope emotionally with care and treatment

There is a risk that due to the language barrier patients did not always receive support to cope emotionally with their care and condition.

Notices in the patient waiting room told patients how to access a number of support groups and organisations however these were all in English.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them, although this was only available in English.

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. As part of the CCG the practice are able to refer patients to a multi-disciplinary hub where they can be seen by specialists and access social care.

- The practice offered extended hours appointments on a Wednesday and Thursday evening until 7.30pm for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had difficulty attending the practice.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There was a ramp access to the main entrance of the surgery.
- There was a toilet that was identified for disabled patients however this was not easily accessible, did not have any grab rails or easy to operate taps or lock. There was also no alarm to call for help.
- There were no dedicated baby changing or breast feeding facilities although staff told us patients could use an empty clinical room if one was available.
- There was a hearing loop and translation services available.
- The CCG medicines management lead had updated the clinical system which allowed basic information about coughs and colds to be printed in Urdu.
- Staff we spoke with could not describe any adjustments that the practice had made to assist patients with visual impairments and could not give us any examples of how they would help these patients.
- The practice told us they had met with the local coroner to assess how they could ensure that death certificates were produced in a timely manner. This was in order to assist families where their preference was that a religious ceremony should take place as soon as possible after death.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11.30am every morning and 2.30pm to 5pm daily. Extended surgery hours were offered between 6.30pm and 7.30pm every Wednesday and Thursday evening. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

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

- 45% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 69% and national average of 75%.
- 33% of patients said they could get through easily to the surgery by phone (CCG average 64%and national average 73%).
- 16% of patients said they usually get to see or speak to the GP they prefer (CCG average 53% and national average 59%).

Patient comment cards told us that they were able to get urgent appointments when they needed them but found it difficult to get prebookable appointments.

The practice told us that last year they had a review of their access carried out by an external expert and they had acted on the recommendations. As a result the practice had increased the number of GP sessions and trialled a triage system. The practice told us that they have high level of appointments that are wasted as patients do not turn up and do not cancel appointments. The practice did not provide evidence that they were monitoring this regularly.

Listening and learning from concerns and complaints

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- The complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that a leaflet was available to help patients understand the complaints system.

We looked at five complaints received in the last 12 months and found that they were not all dealt with satisfactorily or in a timely way. Where complaints were investigated we saw evidence that there was openness and transparency with dealing with the complaint. Investigations of complaints were not well documented and the practice did not provide evidence that lessons were learnt from concerns and complaints were shared appropriately to improve the quality of care. The practice did not provide evidence of actions taken from complaints to improve the quality of care.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision to deliver high quality care and promote good outcomes for patients. There were no realistic plans to achieve the vision values and strategy for patients. The vision and values we saw were around development of new premises. Staff did not understand how their role contributed to achieving the strategy.

The governance arrangements and their purpose were unclear staff were unclear about who had the authority to make decisions. For example when we asked staff how they would register a patient with no fixed address they told us they would contact the partner not the site leads. When we asked staff to provide evidence of recruitment and training records there was confusion about whether documents were held at this location or at the providers main site.

There is no effective system for identifying, capturing and managing issues and risks. Significant issues that threatened the delivery of safe and effective care were not identified or adequately managed. For example significant events were not always recorded and risk assessments such as Legionella were not completed.

Governance arrangements

- There was a staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was not maintained.
- There was not a programme of clinical and internal audit in place and staff told us that no clinical audits had been done in the last year.
- There were some arrangements for identifying, recording and managing risks; however there were not robust arrangements in place to implement mitigating actions.

Leadership and culture

Leaders do not have the necessary capacity or capability to lead this service effectively because they are not present.

The partners were out of touch with what is happening during day-to-day services, for example the partner was unaware that there was no emergency medicine on site to treat bradycardia.

Quality and safety were not the top priority for leadership for example there was no use of clinical audit and significant events were not always recorded and learning from significant events was not always shared with appropriate staff.

The partners in the practice had the experience to run the practice. Staff told us that the partners were not visible in the practice and that they rarely perform clinical duties in the practice. Staff told us that the clinical lead and office manager were approachable and took the time to listen to members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology.
- They did not always keep written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by their line managers.

- Staff told us the practice did not hold regular team meetings, although we did see evidence of some meetings at management level.
- Staff said they felt respected, valued and supported.

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

There is poor collaboration or cooperation between teams for example little interaction was evidenced between GPs and nurses for instance there was no evidence of clinical supervision or peer review.

The service did not respond to what people who use services or the public say for example patient survey results regarding care and involvement in treatment. However the practice had asked a consultant to review their access to appointments in early 2015 and acted on their recommendations.

Are services well-led?

Inadequate

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice had installed an electronic monitoring station in a curtained area of the waiting room which enabled patients to measure their height, weight and blood pressure.
- Staff told us they would discuss any concerns or issues with colleagues and management.

Continuous improvement

There was little innovation or service development. There was minimal evidence of learning and reflective practice. We did not see evidence of a focus on continuous learning and improvement within the practice. Staff told us that they had focused on long term conditions to improve their performance and the practice had identified a higher than average number of diabetic patients.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. The practice could not provide evidence that they had done all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users with disabilities. The practice did not provide evidence of gas safety checks for the building. They had failed to monitor prescription paper and ensure it was secure within the practice. This was in breach of regulation 12(1)(2)(d)(g) 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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered provider did not do all that was reasonably practicable to ensure the privacy of service users. This was in breach of regulation 10 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. Ensure that they have done everything reasonably practicable to provide safe care and treatment to patients whose first language is not English due to the practice telling us that 86% of their population is Urdu speaking and does not have English as their first language. They had failed to risk assess the storage of oxygen within the practice. The practice could not provide evidence of training or understanding of the Mental Capacity Act 2005. The practice did not provide evidence of a risk assessment for Legionella. This was in breach of regulation 12(1)(2) (a)(c)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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 The practice did not demonstrate or provide evidence that all complaints were recorded or investigated thoroughly in a timely manner. This was in breach of regulation 16(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The practice did not demonstrate or provide evidence of a robust system of recording or investigating significant events or sharing learning as a result of these. The practice did not provide evidence of clinical audit or a program of clinical audits or of internal monitoring of performance and effectiveness for the improvement of patient outcomes. The practice did not provide evidence that there was a robust system for managing correspondence and pathology results. This was in breach of regulation 17 (2)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.