Market Hill 8-8 Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Market Hill 8 – 8 Centre on 6 January 2016 under the previous provider Danum Medical Services. The practice was rated inadequate. Following the inspection, due to the serious concerns identified we urgently varied the conditions of the provider's registration with the Care Quality Commission (CQC) under section 31 of the Health and Social Care Act 2008 and stopped the provider Danum Medical Services Limited (DMSL) from providing GP services at Market Hill 8 - 8 Centre from 12 January 2016.

Core Care Links Limited was brought in by NHS England to provide emergency cover shortly after the inspection. NHSE awarded Core Care Links Limited the contract to provide services from Market Hill 8 – 8 Centre in April 2016 for 12 months. This contract has been awarded again and runs for a further 12 months. Core Care Links Limited is a company that provides emergency primary care on behalf of the North East Lincolnshire Clinical Commissioning Group (NELCCG). The company operates as a social enterprise, i.e. it is not for profit. The five Directors are local practising GPs, four of whom work at Market Hill.

We carried out an announced comprehensive inspection at Market Hill 8 – 8 Surgery on 22 June 2017 under the new provider Core Care Links Limited. 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, when things went wrong reviews and investigations into significant events were not thorough enough and lessons learned were not communicated widely enough to support improvement. There was limited evidence to demonstrate the practice had a system in place to revisit changes introduced to assure themselves that the changes were effective and embedded into practice over time.

Summary of findings

- Patients were at risk of harm because systems and processes had weaknesses and were not always effectively implemented in a way to keep them safe. Areas of concern related to medicines management, dealing with emergencies, management of unforeseen circumstances, training and management of patient confidentiality.
- The most recent published QOF results were 88% of the total number of points available which was lower when compared with the clinical commissioning group (CCG) average of 97% and national average of 95%. Exception report was 13.5%, above the CCG average of 8% and comparable to the England average of 10%. The provider provided evidence of QOF data for 2016/2017 which had not been published yet which showed improved performance from 88% to 97%. Exception reporting had improved. QOF (Quality and Outcomes Framework) is a system intended to improve the quality of general practice and reward good practice).
- Four self-employed GPs worked at the practice on a sessional basis. They did not attend clinical team meetings and were not supervised by the practice directors. Mentorship arrangements were in place for the practice nurse and advanced nurse practitioner.
- Staff said they had access to appropriate training to meet their learning needs. We saw evidence to show that staff were supported to develop into new roles. Despite this, the practice could not demonstrate how they ensured mandatory training and update training was completed for all staff. Gaps were identified in mandatory training such as infection control, fire safety, anaphylaxis and basic life support. These gaps put patients at risk. We saw evidence that basic life support and anaphylaxis training had been booked for the middle of July 2017.
- The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. For example there was a backlog of letters that required coding and patient records that required summarising. We noted a plan was in place to reduce the summarising backlog.
- The majority of patients said they were treated with compassion, dignity and respect.
- The practice was open between 8am and 8pm Monday to Saturday and 10am to 2pm on a Sunday. GPs offered telephone triage, same day and routine appointments on a daily basis and on a Saturday a sit and wait service was available between 1pm and 3pm. One GP was on duty at any given time.
- Results from the national GP patient survey published in July 2017 showed that patient's satisfaction to questions on how they could access care and treatment was below local CCG and national averages in six out of the seven questions asked.
- The practice had a practice improvement plan in place which reflected the vision and values and was regularly monitored although this did not accurately reflect our findings.
- The practice has good vision but governance implementation is poor, lack of clear corporate and clinical governance leadership. Despite the issues we identified for improvement there was a focus on continuous learning and improvement at all levels within the practice. It was evident the directors were focused on delivering improvement for the patients at Market Hill and despite the contractual challenges the provider was progressing with initiatives to deliver some of this.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- 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.

In addition the provider should:

- Review the arrangements in place for referring patients to other services for further investigation/support.
- Review the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if appropriate.
- Review the availability of non-urgent appointments, waiting times and continuity of care.
- Ensure staff fully understand their role in the chaperone process.

Summary of findings

- Review the arrangements for managing complaints.

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.

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 things went wrong reviews and investigations into significant events were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- There was limited evidence to demonstrate the practice had a system in place to revisit changes introduced to assure themselves that the changes had been effective and embedded into practice over time.
- Patients were at risk of harm because systems and processes had weaknesses and were not always effectively implemented in a way to keep them safe. Areas of concern found related to medicines management, dealing with emergencies and management of unforeseen circumstances, training and management of patient confidentiality.

Are services effective?

Inadequate

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

- The most recent published QOF results were 88% of the total number of points available which was lower when compared with the clinical commissioning group (CCG) average of 97% and national average of 95%. Exception report was 13.5%, above the CCG average of 8% and comparable to the England average of 10%. The provider provided evidence of QOF data for 2016/2017 which had not been published yet which showed improved performance from 88% to 97%.
- There was some evidence that audit was driving improvement in patient outcomes. Whilst audits were being undertaken, consistent evidence of continuous quality improvement was not available to demonstrate that all audits were routinely revisited over time to ensure that any changes introduced were embedded into practice and were working effectively.
- Four self-employed GPs worked at the practice on a sessional basis. They did not attend clinical team meetings and were not supervised by the practice directors. Mentorship arrangements were in place for the practice nurse and advanced nurse practitioner.

Summary of findings

- Staff said they had access to appropriate training to meet their learning needs. We saw evidence to show that staff were supported to develop into new roles. Despite this, the practice could not demonstrate how they ensured mandatory training and update training was completed for all staff.
- The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. For example there was a backlog of letters that required coding and patient records that required summarising.
- Multi-disciplinary working was taking place but record keeping was limited or absent.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. For example 81% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%. 73% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- The majority of patients said they were treated with compassion, dignity and respect.
- Some information for patients about the services was available in different languages. The practice had recently employed a Polish speaking receptionist to improve engagement with that patient population group.
- The practice's computer system alerted GPs if a patient was also a carer. Approximately 1% of patients registered at the practice had been identified as carers.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for being responsive.

- The practice was open between 8am and 8pm Monday to Saturday and 10am to 2pm on a Sunday. GPs offered telephone triage, same day and routine appointments on a daily basis and on a Saturday a sit and wait service was available between 1pm and 3pm. One GP was on duty at any given time.

Summary of findings

- Results from the national GP patient survey published in July 2017 showed that patient's satisfaction to questions on how they could access care and treatment was below local CCG and national averages in six out of the seven questions asked.
- 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.
- Patients could get information about how to complain in a format they could understand.

Are services well-led?

Inadequate

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

- The practice has good vision but governance implementation is poor, including lack of clear corporate and clinical governance leadership. Staff were clear about the vision and their responsibilities in relation to it.
- The practice had a practice improvement plan in place which reflected the vision and values and was regularly monitored although did not accurately reflect our findings.
- The provider Core Care Links Limited (CCL) was restricted in planning for the short term only due to the 12 month contracts being offered by NHS England.
- The practice had an overarching governance framework which contributed to the delivery of the practice improvement plan. However implementation of the governance framework was not robust enough to always provide assurance that safe good quality care was being provided. Whilst we saw evidence of improvement since CCL took over as the service provider at Market Hill there were still a wide range of areas that required improvement.
- The governance and management arrangements at the practice required reviewing to ensure clear leadership of the practice.
- Despite the issues identified for improvement there was a focus on continuous learning and improvement at all levels within the practice. It was evident the directors were focused on delivering improvement for the patients at Market Hill and despite the contractual challenges they were progressing with initiatives to deliver some of this.

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, effectiveness and being well-led, requiring improvement for caring and responsive. The issues identified overall affected all patients including this population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice had approximately 175 patients over the age of 65 years, with 45 being over 75 years. For those patients the practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital. However we found evidence that records were not always updated to reflect changes.
- Where older patients had complex needs, the practice shared summary care records with local care services. However we noted a back log in coding and summarising of patient records.
- Older patients were provided with health promotion advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Inadequate

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority. The practice had recently arranged for a nurse to undertake diabetes training to improve patient care. They had also recently employed a nurse with experience of chronic disease management.

Summary of findings

- Data from 2015/2016 QOF showed performance for diabetes related indicators was below the CCG and national averages. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 64% compared to the England average of 78%. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2015 to 31/03/2016) was 70% compared to the national average of 80%. Exception reporting for diabetes was 14% compared to the national average of 12%. More recent unpublished data for 2016/2017 showed improvement in this data.
- The practice was now following up on patients with long-term conditions discharged from hospital. However we found evidence that records were not always updated to reflect changes.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Families, children and young people

Inadequate

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

- From the sample of documented examples we reviewed we found there were 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. The practice demonstrated they had taken action to improve the management of safeguarding at the practice following feedback from the local safeguarding team.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 66%, which was lower than the CCG average of 84% and the national average of 81%. The practice had identified this as an area that required improvement and had put in place a range of measures to improve patient uptake and to catch up with patients that had previously been missed. This was particularly important as the practice had 1977 female patients between the ages of 16 to 55 years. Unpublished QOF data for 2016/2017 showed an 11% increase in performance to 77%.

Summary of findings

- The practice worked with midwives, health visitors and school nurses to support this population group.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications. However gaps in recording made it difficult to provide assurance that requests for same day emergency appointments were fulfilled.

Working age people (including those recently retired and students)

Inadequate

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and Saturday and Sunday appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

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

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- Inappropriate arrangements were in place to register patients with no fixed address. Following the inspection the practice put in place a new policy which defined that homeless patients' could register with the practice using the practice address.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients assessed as needing them.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

For example, advance meetings took place with agencies such as the probation service to ensure the practice was fully aware of the needs of the individual and the arrangements to be put in place.

- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The system in place for managing changes to patient medication from secondary care was not always effective. Robust systems were not in place to ensure that all patients taking high risk medicines attended for regular monitoring in line with National guidance.

People experiencing poor mental health (including people with dementia)

Inadequate

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

- The practice carried out advance care planning for patients living with dementia.
- 100% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was above the national average of 84%.
- Systems were not in place to ensure that all patients taking high risk medicines attended for regular monitoring in line with National guidance.
- Performance for mental health related indicators was mixed; some comparable and some above national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had had a comprehensive, agreed care plan documented in their record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 84% compared to the national average of 89%. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of blood pressure in the preceding 12 months was 100% compared to the national average of 89%. Exception reporting for mental health was 12% compared to the national average of 11%.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2017. The results showed the practice was performing below the national average in 20 out of the 23 questions asked. The other three were comparable to national averages. 384 survey forms were distributed and 89 were returned. This represented 1.7% of the practice's patient list.

- 69% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 58% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 60% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the CCG average of 77% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to and on the day of our inspection. We received feedback from 10 patients, nine of which were positive about the standard of care received and access to appointments. One patient reported not being treated with dignity and respect, poor access to appointments and not being involved in their care.

We spoke with two patients during the inspection. They told us there had been considerable improvement in the practice in the last 18 months. Particular GPs were identified as being excellent although continuity of care was not always possible.

Results from the Friends and Family Test for the last 12 months showed 100 patients were extremely likely, 63 likely, 14 neither likely or unlikely, 14 unlikely & 7 extremely unlikely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- 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.

Action the service SHOULD take to improve

- Review the arrangements in place for referring patients to other services for further investigation/support.
- Review the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if appropriate.
- Review the availability of non-urgent appointments, access to female GPs, waiting times and continuity of care.
- Ensure staff fully understand their role in the chaperone process.
- Review the arrangements for managing complaints

Market Hill 8-8 Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector, a CQC pharmacist specialist and a shadowing GP SPA on induction.

Background to Market Hill 8-8 Surgery

Market Hill 8 – 8 Surgery is located at The Ironstone Centre, Scunthorpe, North Lincolnshire, DN15 6HX. The practice shares occupancy of the Ironstone Centre with other practices and healthcare providers. A community car park with associated fees is located outside of the Centre.

The practice has an Alternative Provider Medical Services (APMS) contract with NHS England and North Lincolnshire Clinical Commissioning Group (CCG). The total practice patient population is 5,377 covering patients of all ages.

The proportion of the practice population differs from the England average with more people in the 20 – 39 and 0 – 9 age range and less in the 65 plus age range when compared to the England average. The practice scored two on the deprivation measurement scale, the deprivation scale goes from one to ten, with one being the most deprived. People living in more deprived areas tend to have a greater need for health services.

The Provider is Core Care Links Limited (CCL). The staff team comprises of five directors and four self-employed GP's. There is an advanced nurse practitioner, two practice nurses, two health care assistants and a range of administration staff. There is currently no practice manager. Recruitment to this post is being reviewed. Some management support is being provided by a service manager from CCL.

The practice is open between 8am and 8pm Monday to Saturday and 10am to 2pm on a Sunday. GPs offer telephone triage, same day and routine appointments on a daily basis and on a Saturday a sit and wait service was available between 1pm and 3pm.

The practice has opted out of providing out of hours services (OOHs) for their patients. When the practice is closed the OOHs care is provided by GP Out of Hours Service based at Scunthorpe Hospital. This service also provided by Core Care Links Limited for the whole of Scunthorpe and the locality.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting;

Detailed findings

- We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and NHS North Lincolnshire CCG to share what they knew. We carried out an announced visit on 22 June 2017.

During our visit;

- We spoke with a range of staff including a director from the provider Core Care Links, two self-employed salaried GPs, an advanced nurse practitioner, a practice nurse, a service manager, administration staff and patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a 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.
- Looked at information the practice used to deliver care and treatment plans.

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 living 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. Core Care Links (CCL) did not commence the contract until April 2016 and therefore is not the provider for the QOF year referred to.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events. However the system for reviewing and disseminating to staff was not always effective.

- A recording form was available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed significant event records which showed what action had been taken. There was clear evidence that SEAs were being reported, recorded and acted on. There was evidence that SEAs were discussed in clinical meetings but not all clinical staff attended these meetings. Minutes were available and circulated to staff although it is unclear whether these were read and understood as there was a lack of knowledge by a small number of staff about particular SEAs which formed part of their role. The practice did not currently have a system in place for carrying out a planned review of changes introduced to determine their effectiveness and to assure themselves that changes had been embedded into practice. For example following a SEA, a process had been put in place to ensure that all cases of children under five were seen that day if needed. On the day of the inspection the process in place did not provide assurance that this process was being followed as there were gaps in the recording and we were unable to see when patients had been booked in to be seen as the recording tool referred to the word 'booked' only.
- The practice management informed us they had recently identified that there were recurring themes in SEAs and had started to take action to investigate the issues further. They also informed us they had identified that SEAs were not always being appropriately followed through and monitored.

Overview of safety systems and processes

The practice did not always have clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- 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. We saw evidence that when the provider first took over the practice the local safeguarding team had raised concerns regarding new registration children under the age of five years not being referred to child health. There was evidence the practice had acted to address these concerns.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. The lead GP was trained to child safeguarding level 3. The training record provided to us showed gaps in the completion of safeguarding children and adults training. One GP had not completed safeguarding children training and one GP and the health care assistant had not completed safeguarding adults training. Certificates to confirm completion of training were also not available for some other members of the clinical team.
- Notices 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 (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 chaperone policy was updated following the inspection to indicate that the chaperone must stand at the head of the bed and record their presence into the patient's notes.
- Patient records were appropriately stored.
- The practice was inappropriately allowing homeless patients to record a previous address they had lived at. It was confirmed that all correspondence in respect of such patients was sent to these addresses. We requested the practice review this arrangement

immediately. Following the inspection the practice put in place a new policy which defined that homeless patients' could register with the practice using the practice address.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) lead. They had received basic infection control training. Not all staff had received up to date training. There was an IPC protocol. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice did not keep patients safe.

- We saw that requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that prescribed medicines always reflected patients' current clinical needs. The practice had identified a lack of regular monitoring in a recent audit of patients taking medicines to thin the blood and had introduced a process to address this. However there was no system in place to ensure that all patients taking high risk medicines for example methotrexate, attended for regular monitoring in line with National guidance.
- The practice had a system for reviewing hospital discharge and clinic letters. Where changes to medicines were recommended or made, these were highlighted to GPs who made the necessary changes to patients' records. However we found that two out of the six letters we reviewed that required medication changes had not been actioned which put patients at risk of harm. When medicines were prescribed by other care providers, for example the hospital, letters were scanned into the patient record. However we saw specific examples where the medication list was not updated to include these medicines. This meant it was difficult for GPs in the practice to take into consideration any impact the medicines may be having on the patients' condition, side effects or drug interactions when seeing patients.
- We saw that some of the GPs working in the Practice had a GP bag. There were no checks in place to ensure that the contents were in date. In one bag we checked, blood glucose testing strips were past the expiry date and we could not be sure they were suitable for use.
- The practice nurse administered vaccines using Patient Group Directions (PGDs) that had been produced line with national guidance. The nurse had signed all of the 10 PGDs we checked, however two of the 10 PGDs had not been authorised by an appropriate person at the practice.
- Blank prescription forms were handled in accordance with national guidance and kept securely at all times.
- We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. The practice staff were following this, and could describe the action to take in the event of a potential failure.

We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment although organisation of the information was unstructured which could it make it difficult to determine that certain checks had been carried out. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. The practice did not have certifiable evidence to confirm that six of the GPs had completed fire safety training. There were designated

fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Not all staff had received annual basic life support training. Not all clinical staff including those that administered vaccines and immunisations had up to date anaphylaxis training. Not all non-clinical staff understood what action to take in the event of an emergency and where to locate the emergency equipment. The practice informed us this was scheduled for completion in July 2017.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice. The practice did not have an effective system to ensure all GP bags were checked on a regular basis.
- A first aid kit and accident book was available.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2015/2016 showed the practice achieved 88% of the total number of points available. This was below the local clinical commissioning group (CCG) average of 97% and national average of 95%. Exception reporting was 13.5%; this was above the local CCG average of 8% and comparable to the England average of 10%. The current provider did not commence the contract until April 2016 and therefore is not responsible for the 2015/16 data. However, they provided evidence of QOF data for 2016/2017 which had not been published yet which showed the practice had improved its performance from 88% to 97%. Exception reporting also showed improvement.

Data from the 2015/2016 QOF showed:

- Performance for diabetes related indicators was below the CCG and national averages. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 64% compared to the England average of 78%. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2015 to 31/03/2016) was 70% compared to the national average of 80%. Exception reporting for diabetes was 14% compared to the national average of 12%.
- Performance for mental health related indicators was mixed; some comparable and some above national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had had a comprehensive, agreed care plan documented in their record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 84% compared to the national average of 89%. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of blood pressure in the preceding 12 months was 100% compared to the national average of 89%. Exception reporting for mental health was 12% compared to the national average of 11%.

There was evidence of quality improvement including clinical audit:

- There had been four audits commenced since April 2016. Two of these were completed audits where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, recent action taken as a result included better and more appropriate prescribing, review of prescribing of warfarin and the use of a telephone script for receptionists to allow more people to get through on the phone. However, whilst audits were being undertaken, consistent evidence of continuous quality improvement was not available to demonstrate that all audits were routinely revisited over time to ensure that any changes introduced were embedded into practice and were working effectively. For example; in order to ensure that all children under the age of five were seen on the same day a daily emergency list had been put in place. Names were added to this list, triaged by the GP and seen, with additional emergency appointments added if necessary. This was because it had previously been identified that such children were not always being seen on the same day if needed. However there were gaps in the records maintained which would make it difficult for the practice to be assured that the process was providing the outcome intended.

Effective staffing

Inadequate

Are services effective?

(for example, treatment is effective)

- At the time of the inspection, the practice did not have an effective system in place to demonstrate that required training had been undertaken by all staff and to assure them that required training had been completed with certifiable evidence. At the time of the inspection the practice could not demonstrate they had a clear understanding and evidence to show what training staff had and had not completed.
- 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.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. One member of the nursing team who administered vaccines had not received anaphylaxis training.
- The practice did not have an effective system in place to assure them that training required was completed and up to date. For example at the time of the inspection the practice could not assure themselves that staff carrying out cervical screening and vaccination/immunisation had up to date training. Evidence to confirm this had been completed was received post inspection. We identified gaps in other areas of training such as fire safety, infection control, safeguarding children and adults, anaphylaxis and basic first aid. These training gaps put patients at risk of harm. In the week following the inspection the practice submitted information to confirm new arrangements had been put in place to manage training more effectively. Despite this, staff said they were supported to complete role specific training to meet their learning needs. We saw evidence to show that staff were supported to develop into new roles. For example one member of staff had been supported to become an advanced nurse practitioner. Mentorship arrangements were in place for the practice nurse and advanced nurse practitioner. This was carried out by specific directors of CCL.
- Four self-employed GPs worked at the practice on a sessional basis. They did not attend clinical team meetings and were not supervised by the practice directors. Following the inspection the practice informed us they had set up monthly meetings between the self-employed GPs and the Core Care Links (CCL) service manager. This was to share any concerns and to discuss significant events as well as feedback from the clinical director meetings.

Coordinating patient care and information sharing

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

- We looked at a sample of correspondence received into the practice. These letters were scanned and any action points highlighted before sending to the duty Director to review and action. We found three examples out of approximately two hundred that were reviewed that had not been actioned and there was no audit trail to identify which GP it had been sent to if indeed it had.
- We identified a backlog of approximately 1000 letters for filing from November 2016 that had been scanned and actioned but not coded which could put patients at risk of harm
- We noted an inconsistent internal administrative approach by GPs when referring patients to other services which may make it difficult for the practice to effectively monitor how referrals are managed. For example some GPs used paper; some used email, and some used electronic tasks." The practice had a backlog of 296 patient records that required summarising onto the individual patient record. This had been in place since January 2016 when CCL took over the practice. We saw evidence the practice had recently put a plan in place to start to address this backlog.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. We were told that regular meetings took place with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs. There were no minutes available of these meetings to share with staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). All staff had completed MCA training
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent although this was not always appropriately recorded. For example, written consent was not obtained for joint injections.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- No evidence was made available to show consent was monitored through patient record audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on drug dependency, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 66%, which was lower than the CCG average of 84% and the national average of 81%. The practice had identified this as an area that required improvement and had put in place a range of measures to improve patient uptake and to catch up with patients that had previously been missed. This was particularly important as the practice had 1977 female patients between the ages of 16 to 55 years. The practice had been using a member of staff from the provider's other practice to fill current staffing gaps. The new practice nurse commenced employment on the 5th June and pending training sign off would be offering cytology sessions on a weekly basis. Cytology training was also booked for the other practice nurse in September 2017. Unpublished QOF data for 2016/2017 showed a 10% increase in performance to 77%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to local CCG and national averages. Childhood immunisation rates for the vaccinations given up to age two were above the 90% national target at 94% scoring 9.4 out of 10 compared to the national average of 9.1. Vaccinations for five year olds ranged from 84% to 93% compared to the England average of 88% to 94%. The practice had built in 10 child immunisation slots into each nurse's day to ensure the practice had sufficient capacity to support the young patient population; 25.6% of the patient population was under 18.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer.

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 years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- If requested, appointments were scheduled around availability of female GP's.

Nine out of the ten pieces of patient feedback we received was positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. One patient commented that there had been a significant improvement since the last inspection. The negative comment from one patient related to lack of involvement in their care, not being treated with respect and difficulty accessing appointments when needed.

Results from the national GP patient survey published in July 2017 were mixed. Seven out of the nine questions were between 5 – 15% below the national average for its satisfaction scores on consultations with GPs and nurses. Two were comparable to the local CCG and national average.

- 81% of patients said the GP was good at listening to them compared with the local clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 73% of patients said the GP gave them enough time compared to the local CCG average of 87% and the national average of 86%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the local CCG average of 96% and the national average of 95%.
- 69% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local CCG average of 85% and the national average of 86%.
- 94% of patients said the nurse was good at listening to them compared with the local clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 85% of patients said the nurse gave them enough time compared with the local CCG average of 93% and the national average of 92%.
- 92% of patients said they had confidence and trust in the last nurse they saw compared with the local CCG average of 97% and the national average of 97%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local CCG average of 91% and the national average of 91%.
- 75% of patients said they found the receptionists at the practice helpful compared with the local CCG average of 88% and the national average of 87%.

The practice provided evidence that they were exploring customer training opportunities for non-clinical staff as part of the practice improvement plan.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey 2017 in respect of patient involvement in planning and making decisions about their care and treatment were mixed; two below and two comparable with local CCG and national averages.

- 76% of patients said the last GP they saw was good at explaining tests and treatments compared with the local CCG average of 86% and the national average of 86%.
- 65% of patients said the last GP they saw was good at involving them in decisions about their care compared to the local CCG average of 81% and the national average of 82%.

Requires improvement

Are services caring?

- 88% of patients said the last nurse they saw was good at explaining tests and treatments compared with the local CCG average of 90% and the national average of 90%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the local CCG average of 87% and the national average of 85%.

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

- Staff told us there were facilities available to translate information into different languages. Some leaflets in polish were available in the waiting area. We did not see notices in the reception areas informing patients this service was available. The practice was aware of the demography of their patients and had carefully selected a new member of staff who could speak languages other than English which was beneficial in meeting local patient need.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. Approximately 1% of patients registered at the practice had been identified as carers. There was a carer's information board in the corridor. There was no information asking patients if they were a carer in the new patient registration form. Following the inspection the practice submitted evidence to show they had added this question to the new patient registration form.

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice was open between 8am and 8pm Monday to Saturday and 10am to 2pm on a Sunday. GPs offered telephone triage, same day and routine appointments on a daily basis and on a Saturday a sit and wait service was available between 1pm and 3pm. One GP was on duty at any given time.
- Longer appointments were available for patients assessed as needing them.
- Staff were clear and appointments were co-ordinated for those patients that could not be in the practice when certain patients were present, for example children.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Additional training and resources had been introduced into the practice to improve the care of the high number of diabetic patients.
- We were told same day appointments were available for children and those patients with medical problems that require same day consultation. However the recording tool used had gaps in it so did not provide assurance that appointments were offered.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS.
- A hearing loop was located within the Ironstone Centre where the practice was located. Staff said they would use a side room if they experienced difficulty communicating.
- New arrangements had been put in place to ensure patients could access vaccinations and cervical screening.
- The practice had not heard of, considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients received information in formats that they could understand and received appropriate support to help them to communicate. However we were told that of the seven patients on the dementia register, five of them were set up for an appointment text message reminder 24 hours before the appointment and on the day of the appointment itself. Following the inspection reminders were added to the remaining two records. The practice also submitted evidence to show they had made provisional arrangements to commence implementation of the Accessible Standard, such as adding specific questions regarding communication adjustments to the new patient registration form.

Access to the service

The practice was open between 8am and 8pm Monday to Saturday and 10am to 2pm on a Sunday. GPs offered telephone triage, same day and routine appointments on a daily basis and on a Saturday a sit and wait service was available between 1pm and 3pm.

Results from the national GP patient survey published in July 2017 showed that patient's satisfaction to questions on how they could access care and treatment was below local CCG and national averages in six out of the seven questions asked.

- 79% of patients were satisfied with the practice's opening hours compared with the local clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 49% of patients said they could get through easily to the practice by phone compared to the local CCG average of 67% and the national average of 71%.
- 58% of patients described their experience of making an appointment as good compared with the local CCG average of 74% and the national average of 73%.
- 47% of patients said they don't normally have to wait too long to be seen compared with the local CCG average of 60% and the national average of 58%.
- 65% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment, compared with the local CCG average of 85% and the national average of 84%.
- 57% of patients said their last appointment was convenient compared with the local CCG average of 84% and the national average of 81%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 28% of patients said they usually get to see or speak to their preferred GP compared with the local CCG average of 48% and the national average of 56%.

The practice had identified on their improvement plan that access to appointments would be monitored. We looked at the number of appointments offered over a range of weeks and found these were mostly consistent. Fluctuations on occasional weeks ranged from 291 to 369 appointments being offered meaning 68 less appointments were offered one week to another.

Feedback from all but one patient said they could access emergency appointments when needed. NHS choices feedback from July 2016 to date showed eight negative comments in respect of accessing appointments. Negative comments also related to waiting times when at the practice.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The duty director assessed the emergency list daily and contacted the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Due to gaps in the recording on the 'emergency list' we could not be assured that emergency appointments were offered on the same day.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There had been a designated responsible person who handled all complaints in the practice. Arrangements had been put in place for the service manager to manage complaints in the absence of a practice manager. We noted that when the response was sent that it was detailed, apologetic and informative.
- We saw that some information was available asking for feedback but not specific complaint information.

We looked at the complaints received in the last 12 months. We saw complaints were mostly responded to in an appropriate way. We saw an example where concerns had been raised regarding the attitude of a GP on two occasions. There was no evidence of counselling or reflection or training attended that would support the providers assertion that concerns about the attitude of the GP was handled in house.

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 has good vision but governance implementation is poor, including lack of clear corporate and clinical governance leadership.

- The practice had a mission statement which was displayed.
- The practice had a practice improvement plan in place which reflected the vision and values and was regularly monitored.

Governance arrangements

The practice had an overarching governance framework which contributed to the delivery of the practice improvement plan. However implementation of the governance framework was not robust enough to always provide assurance that safe good quality care was being provided. Whilst we saw evidence of improvement since CCL took over as the service provider at Market Hill there were still a wide range of areas that required improvement. There had been a period of instability with the practice management arrangements and whilst some management presence and support had been provided the practice had been without the presence of a practice manager for between three and six months. There was evidence of support for existing staff and discussions of plans for filling the practice manager role.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas and were developing into new roles.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example a director of CCL worked at the practice on a daily basis and reviewed all letters coming into the practice for actioning. They also provided mentoring arrangements to the nursing team. However, we identified risks and issues that had not been identified by the practice. For example the safe management of medicines.
- A comprehensive understanding of the performance of the practice was not always maintained. Planned director meetings took place where performance information about Market Hill was submitted for the directors to consider. We identified a number of concerns in respect of this; namely the frequency of the meetings was not always as planned and the information submitted to the directors was completed by a senior administrator in the absence of the absent practice manager. The submission did not identity many of the risks we found at the inspection. It is acknowledged that other management support was provided to the practice but it was not sufficient enough to allow full oversight of the practice.
- Whilst a programme of continuous clinical and internal audit was used to monitor quality and to make improvements there was little evidence to show that changes implemented were reviewed overtime to determine whether they had been embedded into practice and were effective.
- We were provided with one example of a significant event that a staff member was not aware of which was pertinent to their role.

Leadership and culture

The governance and management arrangements at the practice required reviewing to ensure clear leadership of the practice. It was evident they prioritised safe, high quality and compassionate care and were aware of the challenges facing the population groups. However the restrictions of short term contractual arrangements with NHS England were having an effect on staff morale and practice development. Staff told us the directors and GPs were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

Are services well-led?

Inadequate

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

- The practice held but did not minute a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us that regular non-clinical meetings took place. The four self-employed GPs did not attend clinical meetings and whilst invited, nursing staff could not always attend due to their working patterns. Minutes of these meetings were circulated. We received some feedback to indicate staff would benefit from director presence at non-clinical meetings.
- Staff told us there was an open culture and they felt supported. Staff said they felt respected and valued.

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

There was some evidence that the practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly.
- the NHS Friends and Family test, complaints and compliments received
- staff, generally through staff discussions and meetings.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. It was evident the directors were focused on delivering improvement for the patients at Market Hill and despite the contractual challenges were progressing with initiatives to deliver improvement. The current contract ends in March 2018. Despite this uncertainty for the provider and for staff they demonstrated they were forwarded thinking and involved in remodelling services for the future. For example; the provider had recruited a second health care assistant, an advanced nurse practitioner and had recently submitted a bid with NHSE for a clinical pharmacist.

The practice has signed up staff to train as 'Care Navigators'. This is a national incentive and locally is being led by the CCG. 'Care navigators' can play a crucial role in helping people to get the right support, at the right time to help manage a wide range of needs. This will be of particular benefits for patients and the practice as the practice works closely with agencies such as probation, child protection, drug and alcohol services and housing. The practice also identified they had prioritised those patients that needed to be reviewed first and was systematically working their way through to deliver improvement. Unpublished QOF data supported this drive for improvement.

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 **Care and treatment must be provided in a safe way for service users** **How the regulation was not being met** **The registered persons 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:** • The practice did not have a system in place for carrying out a planned review of changes introduced following significant events to determine their effectiveness and to assure themselves that changes had been embedded into practice. **Not all staff were aware of or involved in discussions regarding significant events.** • The practice was inappropriately allowing homeless patients to record a previous address they had lived at. • The practice was not updating patient records in a timely way. **There was no proper and safe management of medicines. In particular:** • There was no system in place to ensure that all patients taking high risk medicines attended for regular monitoring in line with national guidance. • Changes recommended by secondary care to patient's medicines were not always made. Patient records were not always updated to reflect these changes. • A system for checking GP bags was not in place to ensure that the contents were in date and suitable for use. • Two of the 10 PGDs had not been authorised by an appropriate person at the practice.

This section is primarily information for the provider

Requirement notices

Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular:

- Not all staff had received annual basic life support training.
- Not all clinical staff including those that administered vaccines and immunisations had up to date anaphylaxis training.
- Not all staff had completed safeguarding children and adult training
- Not all staff had completed fire training.
- Not all non-clinical staff understood what action to take in the event of an emergency and where to locate the emergency equipment.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met 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. In particular: • Implementation of the governance framework was not robust enough to always provide assurance that safe good quality care was being provided. • A comprehensive understanding of the performance of the practice was not always maintained.

This section is primarily information for the provider

Requirement notices

- The practice did not have a system in place for carrying out a planned review of changes introduced following significant events to determine their effectiveness and to assure themselves that changes had been embedded into practice.
- There was insufficient management/leadership at the practice.
- Multi-disciplinary meetings were not minuted
- Clinical meetings were not attended by all clinical staff.

There were limited systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- The practice allowed homeless patients to register using a previous address they had previously lived at.
- The practice was not updating patient records in a timely way.

This was in breach of Regulation 17 (1)(2)(a)(b) 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 18 HSCA (RA) Regulations 2014 Staffing **Requirements in relation to staffing** **How the regulation was not being met** **The service 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:** • There was a failure to ensure that staff received mandatory training. • The practice could not demonstrate that staff had completed training in areas such as safeguarding adults and children, fire safety, basic life support, anaphylaxis and infection control.

This section is primarily information for the provider

Requirement notices

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