Dilston Medical Centre

Quality Report

Dilston Medical Centre, 23 Dilston Road, Newcastle Upon Tyne, NE4 5AB
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We first carried out an announced comprehensive inspection of this practice on 8 December 2014. We rated the practice then as requiring improvement for providing safe, effective, caring and well-led care. We rated the practice as inadequate for providing responsive care. We carried out a further announced comprehensive inspection on 7 November 2016. We rated the practice as requiring improvement for providing safe, effective, caring, responsive and well led care.

The full comprehensive reports on the December 2014 and November 2016 inspections can be found by selecting the 'all reports' link for Dilston Medical Centre on our website at www.cqc.org.uk.

We carried out this comprehensive inspection on 25 September 2016 and 4 October 2017, to check whether the provider had followed their action plan and had taken steps to comply with all legal requirements. Overall, the practice is now rated as inadequate.

Our key findings were as follows:

- There was evidence the lack of leadership and oversight in the practice resulted in ineffective systems to identify and respond to emerging and knowable safety risks.
- There was a lack of shared vision within the partnership. The practice did not have effective strategies in place to proactively make sustainable improvements.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. There were concerns about the processes for infection control, handling clinical correspondence and premises were not adequately maintained.
- When things went wrong, reviews and investigations were not always sufficiently thorough and did not always include all relevant people.
- Patients' outcomes were very variable, and sometimes significantly worse, when compared with other similar services.
- There was a continuing trend on the National GP Patient Survey (July 2017) of well below average results.
- There was no evidence that audit was driving improvement in patient outcomes.

Summary of findings

- Patients found it hard to access services because the facilities and premises were not appropriate for the service being provided. The practice had not considered different ways of working to maximise the use of clinical rooms.
- The practice had made improvements to the way they informed patients about the services available.

The areas where the provider must make improvements are:

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure all premises and equipment used by the practice is fit for use.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

In addition the provider should:

- Clarify the policies and procedures for offering a chaperone service and make sure staff are familiar with this policy.
- Improve the arrangements to manage risks where capacity for appointment availability is outmatched by patient demand.

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

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

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

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

Summary of findings

The 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.

- The practice did not effectively assess, monitor and manage risks to patients. The practice missed some opportunities to prevent or minimise harm. They could not effectively assess the risks to the health and safety of patients because staff shortages had led to a build-up of clerical work related to clinical correspondence.
- There were poor control mechanisms to manage risks where capacity for appointment availability was outmatched by patient demand.
- When things went wrong, reviews and investigations were not always sufficiently thorough and did not always include all relevant people. Necessary improvements were not always made when things went wrong.
- Patients were at risk of harm because systems and processes were weak and were not effective or embedded in a way that kept people safe. There were concerns about the processes for infection control, some equipment was not used in line with national guidance and premises were not adequately maintained.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children relevant to their role. Not all staff had received recent training on the safeguarding of vulnerable adults.

Are services effective?

Inadequate

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

- Patients' outcomes were very variable, and sometimes significantly worse, when compared with other similar services. The Quality Outcomes Framework (QOF) for 2016/17 showed the practice had achieved 85.4% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was below the national average of 95.6% and the local clinical commissioning group (CCG) average of 97.7%.

Summary of findings

- The practice did not demonstrate effective leadership in the management, monitoring and improving outcomes for people. There was no evidence that audit was driving improvement in patient outcomes.
- We found ineffective processes in place to handle clinical correspondence and improvements made within this were not sustainable.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. However, the practice approach to this was not always effective.
- Staff had not received regular update training in some areas to support them to provide services in a safe and effective way.
- Staff were aware of current evidence based guidance.
- End of life care was coordinated with other services involved.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services.

- There was a continuing trend on the National GP Patient Survey (July 2017) of well below average results for satisfaction with consultations and involvement in decisions about care.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had made improvements to the way they informed patients about the services available.
- The practice had implemented the local clinical commissioning group's social prescribing initiative, and referred patients with social, emotional or practical needs to a primary care navigator. (Primary care navigators help to connect vulnerable patients with care and support in the community, and provide direct non-medical support.)

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- The practice displayed a number of information posters in the seven most common languages spoken by the practice population. They had held an information session for patients from the Romanian community.
- The practice had started to offer extended hours one morning a week from 7am.
- Patients found it hard to access services because the facilities and premises were not appropriate for the service being provided. The practice had not considered different ways of working to maximise the use of clinical rooms.

Summary of findings

- There were low levels of patient satisfaction with appointment availability.
- There was a continuing trend on the National GP Patient Survey (July 2017) of well below average results with how satisfied patients were with how they could access care and treatment.
- Although the practice had a system for handling complaints and concerns, the processes for listening and learning from complaints were ineffective.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

- There was a lack of shared vision within the partnership. The practice did not have effective strategies in place to make sustainable improvements.
- There was evidence the lack of leadership and oversight in the practice resulted in ineffective systems to identify and respond proactively to emerging and knowable safety risks.
- The practice overarching governance framework was not effective and did not support the practice to identify and act upon areas for improvement. This put the delivery of the strategy and provision of good quality care at risk.
- There was little evidence of learning or reflective working across the way the practice operated. The practice did not have effective processes in place to learn and improve the service delivered, taking into account feedback from patients, significant events, clinical audits or complaints.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people. This is because the practice is rated as inadequate for providing safe, effective, caring, responsive and well-led services. There were, however, examples of good practice.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- 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. They 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 and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. The practice referred patients with social, emotional or practical needs to a primary care navigator to help them access a range of local, non-clinical services, often provided by the voluntary and community sector.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. This is because the practice is rated as inadequate for providing safe, effective, caring, responsive and well-led services.

We also found:

- 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 begun to implement the Year of Care to help patients to manage their own diabetes; however, it was too early to see the impact of this. They intended to roll this out across other long-term conditions.

- The practice performance against diabetes indicators was lower than comparators. The practice achieved 64.3% of the points available for this on the Quality Outcomes Framework (QOF) 2016/17. This compared to an average performance of 93.7% across the CCG and 90.9% national average.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. This is because the practice is rated as inadequate for providing safe, effective, caring, responsive and well-led services. There were, however, examples of good practice.

- 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.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics. However, attached healthcare staff told us information sharing was not always timely and effective.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired and students). This is because the practice is rated as inadequate for providing safe, effective, caring, responsive and well-led services.

We found:

- The needs of these populations had been identified and the practice had adjusted the services it offered. For example, the practice had started to offer extended opening hours one morning a week from 7am.
- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- However, patient feedback demonstrated low levels of satisfaction with access to appointments.
- Some patients told us the way the practice worked made it difficult for them to make best use of the service offered, as it conflicted with their working commitments.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. This is because the practice is rated as inadequate for providing safe, effective, caring, responsive and well-led services. There were, however, examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. However, attached healthcare staff told us that these meetings were sometimes cancelled at the last minute and there weren't always clear actions agreed and delivered as a result of these meetings.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary

Summary of findings

organisations. The practice referred patients with social, emotional or practical needs to a primary care navigator to help them access a range of local, non-clinical services, often provided by the voluntary and community sector.

- 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). This is because the practice is rated as inadequate for providing safe, effective, caring, responsive and well-led services.

We found:

- The practice carried out advance care planning for patients living with dementia.
- 84.6% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Overall, the practice performance against mental health indicators in the QOF was much lower than comparators. The practice achieved 75.6% of the points available. This compared to an average performance of 95.3% across the CCG and 93.6% national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations. The practice referred patients with social, emotional or practical needs to a primary care navigator to help them access a range of local, non-clinical services, often provided by the voluntary and community sector.

Summary of findings

- 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 latest GP Patient Survey published on 6 July 2017 showed lower levels of patient satisfaction with their overall experience of the GP surgery (at 71%). This was lower than the local clinical commissioning group (CCG) average of 87% and the England average of 85%. This was also lower than the previous year's (published July 2016) satisfaction level of 74%. There were 391 survey forms distributed for Dilston Medical Centre and 63 forms returned. This was a response rate of 16% and equated to approximately 0.7% of the practice population.

Of those patients who responded:

- 60% found it easy to get through to this surgery by phone. This compared with the CCG average of 77% and a national average of 71%.
- 74% found the receptionists at this surgery helpful. This compared with the CCG average of 88% and a national average of 87%.
- 73% were able to get an appointment to see or speak to someone the last time they tried. This compared with the CCG average of 84% and a national average of 84%.
- 53% said the last appointment they got was convenient. This compared with the CCG average of 81% and a national average of 81%.
- 64% described their experience of making an appointment as good. This compared with the CCG average of 74% and a national average of 73%.
- 27% felt they do not normally have to wait too long to be seen. This compared with the CCG average of 60% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 18 comment cards which were mostly positive about the standard of care received. Of these 13 included wholly positive comments about the service, with patients using phrases such as very helpful; caring; good service; and, good treatment to describe the practice and service they receive. The other five cards also expressed positive sentiments; however, they also included some concerns. Four of these related to waiting times for appointments and one commented on the need for renovation of the practice premises and the need for additional seating in the waiting area.

We spoke with five patients during the inspection. Although they stated generally staff were approachable, committed and caring, three of these patients also told us there were problems in accessing appointments.

We asked the practice to provide us with the results of their friends and family test questionnaires for the last three months. (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). The practice told us they were unable to access this data. However, data from NHS England confirmed there were no FFT results for May, June or July 2017 for the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure all premises and equipment used by the practice is fit for use.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Clarify the policies and procedures for offering a chaperone service and make sure staff are familiar with this policy.

Summary of findings

- Improve the arrangements to manage risks where capacity for appointment availability is outmatched by patient demand.

Dilston Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP specialist adviser.

Background to Dilston Medical Centre

Dilston Medical Centre is registered with the Care Quality Commission to provide primary care services.

The practice provides services to approximately 8,900 patients from one location, which we visited as part of this inspection:

- Dilston Medical Centre, 23 Dilston Road, Newcastle Upon Tyne, NE4 5AB.

Dilston Medical Centre is a medium sized practice providing care and treatment to patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of the NHS Newcastle Gateshead clinical commissioning group (CCG).

The practice has two GP partners (both male). The practice employs two long-term locum GPs (one male, one female). They employ a nurse practitioner, a practice nurse, a career start nurse (all female) and seven staff who undertake reception and administrative duties. A practice manager is supporting the practice on an interim basis. They work at another local practice and provide one day of management support a week.

NHS 111 service and Vocare Limited (known locally as Northern Doctors Urgent Care) provide the service for patients requiring urgent medical care out of hours.

The practice is open at the following times:

- Monday, Tuesday, Thursday and Friday 8:30am to 6pm.
- Wednesday 8:30am to 12pm and 1pm to 6pm

There is a local contract with the out of hour's service to provide telephone cover between 6 and 6:30pm. From 1 October 2017, the practice opens from 7am every Wednesday to offer extended opening hours for patients.

Appointments are available at the following times:

- Monday, Tuesday, Thursday and Friday 8:30am to 11:40am then 1pm to 5:20pm.
- Wednesday 8:30am to 11:40am then 2pm to 5:20pm.

The practice population includes more patients who are under 40 years of age but fewer patients who are aged over 45 years of age, when compared to the England average. The practice had a high proportion of patients from ethnic minorities (Public Health England data estimates this as mixed ethnicity 2.7%, Asian 34.6%, black 5% and other non-white ethnic groups at 4.5%). The practice told us that this is constantly changing as new people move to the area.

Information from Public Health England placed the area in which the practice is located in the second most deprived decile. In general, people living in more deprived areas tend to have a greater need for health services. Average male life expectancy at the practice is 75 years compared to the national average of 79.4 years. Average female life expectancy at the practice is 80.3 years compared to the national average of 83.1 years.

Why we carried out this inspection

We undertook an announced comprehensive inspection of Dilston Medical Centre on 8 December 2014 under section

Detailed findings

60 of the Health and Social Care Act 2008 as part of our regulatory functions. We rated the practice as requiring improvement overall, and there were breaches of legal requirements.

We carried out an announced comprehensive inspection on 7 November 2016 to check whether the provider had taken the action they said they would take to address shortfalls in relation to legal requirements, identified during our comprehensive inspection on 8 December 2014. Although the practice had made some progress, we continued to rate them as requiring improvement overall. This was because we found there were areas where the practice must make improvements.

We carried out this announced comprehensive inspection on 25 September 2017 and 4 October 2017 to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, for example, the local clinical commissioning group (CCG) and NHS England to share what they knew. We carried out announced visits on 25 September 2017 and 4 October 2017. During our visit we:

- Spoke with a range of staff (GP partner, practice nurse, the supporting practice manager and administrative and receptionist staff).
- Observed how patients were being cared for in the reception area and spoke with patients who used the service.
- We received email feedback from members of the extended community healthcare team who were not employed by, but worked closely with the practice.
- 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.
- 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 with dementia).

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

Inadequate

Are services safe?

Our findings

At our previous inspection in November 2016, we rated the practice as requiring improvement for providing safe services as we identified concerns in relation to how the practice learnt from safety information and incidents; ensured a clean and hygienic environment; managed medicines and monitored and responded to risks.

We identified the practice had not made all the necessary improvements and also identified some new concerns when we undertook a follow up inspection in September and October 2017. The practice is now rated as inadequate for providing safe services.

Safe track record and learning

In November 2016, we found evidence of a repetition of similar significant events and ineffective action taken by the practice to reduce the risk of reoccurrence. They did not provide a written apology where the practice identified a patient had experienced or was at risk of harm, unless the patient made a complaint about it.

At this inspection we found although the practice had taken action to develop their approach to significant events this had not been successful. When things went wrong, reviews and investigations were not always sufficiently thorough and did not always include all relevant people. Necessary improvements were not always made when things went wrong.

The practice had carried out four bi-monthly audits to support them to improve their reporting and learning from significant events. However, there were a high number of similar issues identified across all four audits relating to clinical record keeping. There was no clear improvement plan in place to address this.

The staff we spoke with were unable to tell us about any improvements made as a result of significant events. They could not recall making any significant event referrals themselves. However, they were able to tell us there was a process in place and what they would do if they identified a significant event. The practice did not have a process in place to involve locum GP staff in the significant event process, despite their high current use of locum staff.

We did find 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).

We also reviewed the system for informing clinical staff about patient safety alerts. We found the practice had an auditable process for checking clinicians were aware of and had taken the necessary action for patient safety alerts.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to minimise risks to patient safety. However, some of these were not effective or embedded in a way that kept people safe. For example, there were concerns about the processes for infection control, some equipment used was contrary to national guidance and premises were not adequately maintained.

- Arrangements for safeguarding reflected relevant legislation and local requirements. 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 found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children relevant to their role. GPs were trained to child protection or child safeguarding level three. However, not all staff had received training on the safeguarding of vulnerable adults.

The November 2016 inspection identified chaperones had not received a suitable Disclosure and Barring Service (DBS) check to ensure they were suitable to undertake this role. (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).

In the September and October 2017 inspection we found:

- Staff were unclear as to who could act as a chaperone within the practice. However, all non-clinical staff we spoke with told us they had not undertaken the role of chaperone within the last twelve months.

- We reviewed the practice policy on chaperoning. This stated that any staff member could provide a chaperone service, including experienced receptionists.
- We checked staff files and found all practice nurses had been subject to a DBS check. The supporting practice manager had also started the process to DBS check all non-clinical staff. They told us only the practice nurses offered a chaperone service and confirmed they would clarify this with non-clinical staff.
- A notice in the waiting room advised patients that chaperones were available if required. This was displayed in the most common languages spoken by patients within the practice.

Infection control and cleanliness

In November 2016, we found the poor quality of some of the walls, which was identified in a previous CQC inspection report in December 2014, had not been addressed.

In September 2017, we saw the arrangements had not improved. There were still areas of poor repair to walls in the treatment room storage area, patient toilet, the waiting area and the staff room/kitchen. The practice addressed this between 25 September and 4 October 2017, when we inspected the practice on a second day; the walls had been repainted.

The supporting practice manager told us the practice had previously had the leaking roof fixed, which had caused the damage. However, they were unable to provide documentary evidence of this. The practice provided this information after we sent them the draft inspection report for review, prior to publication.

The practice had carried out an infection control audit on 26/7/2017. This identified a number of concerns, including poor repair of walls, inappropriate furniture for a health care setting, and poor levels of cleaning by the contracted cleaning company. They had addressed some minor issues, such as clearing clutter and replacing waste bins with ones that were foot operated. However, there was no progress on some areas. For example, the practice had not told the cleaning contractor about their dissatisfaction with the level of cleaning provided or purchased more suitable furniture. There was disagreement within the GP partnership as to how to progress the action plan identified as a result of the infection control audit.

A visit was planned within a few weeks by the local clinical commissioning group (CCG) infection prevention and control nurse to help support the practice meet expected standards.

We found there were some areas where infection control procedures within the practice were ineffective. For example, the flooring within the treatment room used for minor surgeries was not coved to allow for easy cleaning and disposable consultation room privacy curtains had not been replaced since October 2016. National Patient Safety Agency guidance states (in 'The national specifications for cleanliness in the NHS') these should be changed every six months. There were cleaning schedules in place, but the practice did not feedback their dissatisfaction with the level of cleaning carried out.

Medicines Management

In November 2016, we found not all Patient Group Directives (PGDs) were appropriately authorised to enable practice nurses to administer medicines safely based on these. Also the system to monitor the use of blank prescription pads was inadequate.

In September 2017, we found the practice had made improvements in these areas. There were now appropriately authorised PGDs in place to enable practice nurses to administer medicines safely based on these. There was a system to track and monitor the use of blank prescription pads.

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

- There were processes for handling repeat prescriptions which included the review of high risk medicines. 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. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role.
- We identified the practice used a domestic refrigerator to store temperature sensitive medicines, such as vaccinations. Guidance from Public Health England

states that only properly validated pharmaceutical refrigerators should be used for storing medicines of this type. The practice informed us they had ordered specialist refrigerators after the inspection on 25 September 2017. We checked on 4 October 2017 and found the practice now had two specialist validated pharmaceutical refrigerators in place and operational within the practice.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. 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

Overall, we found the practice did not effectively assess, monitor and manage all risks to patients. The practice missed some opportunities to prevent or minimise harm.

In November 2016, we found staff and patients thought there were not enough clinical resources.

In September 2017 and October, we found there had been no improvements made and further staff shortages had increased the risks to patients. Staffing numbers had reduced; in particular, management capacity within the practice had decreased with both the practice manager and assistant practice manager having resigned.

The practice was aware they were running on a lower staffing level than they thought they needed. They had plans in place to recruit an assistant practice manager to provide more management support within the practice and interviews for this role were taking place within two weeks. However, they were constrained in the number of clinicians they could deploy at any one time, due to the number of clinical rooms available. The patient list size had increased significantly over the last year, and the building constraints impacted on their ability to meet the needs of this increased patient list size. The practice had not proactively planned to maximise the use of the clinical rooms they had available across the working day. The high number of clinical sessions covered by locum GPs impacted on the continuity of care for patients.

There were poor control mechanisms to manage risks where capacity for appointment availability was outmatched by patient demand. They had not proactively addressed this by formalising agreements with other local services, such as the local walk in centre, to ensure safe escalation routes when they exceeded capacity. This minimised the opportunities to support continuity of care for those patients who sought the services of the walk in centre when they were unable to get an appointment at the practice.

The practice was not able to effectively assess the risks to the health and safety of patients and to do all as reasonably practical to mitigate any such risks, because staff shortages had led to a build-up of clerical work related to clinical correspondence. The practice addressed this back log between 25/9/2017 and 4/10/2017 by staff working overtime at the weekend. We received feedback from stakeholders of a similar concern with clinical correspondence, within the last year.

We also found:

- There was a health and safety policy available.
- 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).
- The practice fire risk assessment was dated as last updated in June 2013. In November 2016, we found they had not completed a fire drill when the practice was open to patients as they were concerned that the local area did not offer a suitable place for assembly due to the busy road. In September and October 2017, we found the practice had still not carried out a fire drill. They told us they had fire safety training planned for 13 October 2017, when they planned to carry out a full fire evacuation drill.
- During the practice infection control audit (carried out in July 2017) the practice had identified a health and safety risk relating to the hot water boiler placed in the patient toilet. They had not fully considered the risks associated with this or taken remedial action to address the concerns they did have.

Inadequate

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents, but improvements were needed in relation to providing safety training to staff.

- Staff had not received annual updates on resuscitation and basic life support, as recommended in guidance produced by Resuscitation Council (UK). The practice had purchased an e-learning system to support staff to receive the training they needed to do their job and keep people safe. However, not all staff had undertaken this update training within the last year. There was a risk that staff may not recognise or respond appropriately to signs of deteriorating health and medical emergencies.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had 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

At our previous inspection in November 2016, we rated the practice as requiring improvement for providing effective services as we identified there was little evidence of quality improvement work led by or initiated by the practice and the practice performed lower than others in a number of areas. Although there was a diverse patient group, health information literature was only available in English language versions within the practice.

At this inspection, we found there were areas where further improvements must be made. The practice is now rated as inadequate for providing effective services.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including 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.

In November 2016, the practice did not demonstrate that national clinical guidelines had been adopted to support clinicians during consultations.

At this inspection staff were able to give examples of how they used NICE best practice for improvements they had made for patients with diabetes. They had begun to implement the Year of Care; however, it was too early to see the impact of this. This approach helps patients to manage their own diabetes, by using care planning as a central component to drive a proactive process of care, with improved patient involvement and self-management. They had also implemented local guidelines for caring for dying patients.

Management, monitoring and improving outcomes for people

Patients' outcomes were very variable, and sometimes significantly worse, when compared with other similar services. The practice did not demonstrate effective leadership in the management, monitoring and improving outcomes for people. Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2016/17 showed the practice had achieved 85.4% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was much lower than the national average of 95.6% and the local clinical commissioning group (CCG) average of 97.7%. The practice had 6.8% clinical exception reporting. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.) This compared to a CCG average of 10.1% and a national average of 10%.

This practice was an outlier on three QOF national clinical targets for 2015/16. There were two indicators relating to mental health conditions and one related to diabetes. We checked the progress the practice had made in these two areas, by reviewing the data for 2016/17.

- In 2015/16, the practice achieved 43.8% of the points available in QOF for mental health indicators. (Compared to a CCG average of 94.7% and a national average of 92.8%.) Data for 2016/17 showed a slightly improved performance across the indicators, with the practice achieving 75.6% of the points available. This compared to an average performance of 95.3% across the CCG and 93.6% national average. For example, in 2015-16, 27.9% of patients with schizophrenia, bipolar affective disorder and other psychosis had a comprehensive agreed care plan documented within the preceding 12 months. In 2016/17, this had increased to 61.4% of patients. (Compared to a CCG average of 88.9% and a national average of 90.3%).
- In 2015/16 the practice performance against diabetes indicators was also lower than comparators. The practice achieved 67.4% of the points available. This compared to an average performance of 93.5% across the CCG and 89.8% national average. Data for 2016/17 showed slightly lower levels of performance across the indicators, with the practice achieving of the points 64.3% of the available points.

In November 2016, we found there was limited evidence of quality improvement work that was led by or initiated by the practice. In September and October 2017, we found although the practice had some improvements planned, this work had not yet started.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice had carried out an audit of significant events to support them to improve and learn. However, we found this had not supported the required improvements. There was still evidence of repeated incidents and events, mainly relating to clinical correspondence. Similarly, the practice had carried out an audit of infection control procedures, but this had not yet led to the identified improvements.
- The practice had carried out audits requested by the local CCG to support medicines optimisation. For example, the practice had carried out a data collection to identify girls and women prescribed the medicine valproate (a medicine prescribed for epilepsy or bipolar disorder), to ensure they understood the risks and safety issues for unborn children and alternatives were prescribed where appropriate.
- The practice had a clinical audit plan for the following year. This included planned audits for referrals to hospital care, such as obstetrics, gynaecology and cardiology. The practice also planned to audit extended hour appointment use and the number of patients who did not attend appointments.

Effective staffing

Evidence reviewed showed that some staff had the skills and knowledge to deliver effective care and treatment. However, staff had not received regular update training in some areas to support them to provide services in a safe and effective way.

- 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 updates for relevant staff. For example, for those reviewing patients with long-term conditions.
- 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.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. The system to support staff to undertake update and refresher training had been implemented from July and August 2017. The practice had identified the mandatory update and refresher training they required each staff member to undertake. However, staff had not had capacity to undertake this training at the time of the inspection. The supporting practice manager told us they anticipated staffing levels would improve within the next month and they would then schedule dedicated time for staff training and development. However, staff had not received regular updates on basic life support; infection control; fire safety; or the Mental Capacity Act.
- The majority of staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

We found there were not effective and timely processes in place to handle clinical correspondence within the practice. Staff did not have access to timely information. This impacted on their ability to effectively assess the risks to the health and safety of patients and to do all as reasonably practical to mitigate any such risks.

In addition, where there was shared responsibility with other healthcare providers for the care and treatment or where responsibility was transferred, correspondence and other information needed to ensure safe care and treatment was not dealt with in a timely way.

Low staffing levels had resulted in a back log of work, including:

- Clinical letters, such as correspondence with hospital doctors and test results;
- New patient registration forms;
- Requests for records from other practice, when a patient had transferred to a new GP practice;
- Paper clinical records that needed summarising, to ensure clinicians could easily access the information electronically.

There was at least a month's worth of backlog in each of these areas. There was no process in place to ensure a clinician reviewed the details, when there was a delay in the administration of correspondence.

The practice contacted us after we inspected on 25 September 2017, and informed us they had implemented an action plan to address the shortfall in clinical record

keeping by the end of the week. We reviewed the progress they had made with this, when we went out again on the 4 October 2017. We found the practice had addressed this issue. Practice staff had worked weekend overtime to clear this work. We received feedback from stakeholders of a similar concern with clinical correspondence, within the last year. We were concerned this did not demonstrate a sustainable approach to reducing the risk of similar circumstances arising again.

Information was shared between services, with patients' consent, using a shared care record. However, important information about patients was not always shared in a timely way. Meetings took place with other health care professionals on a weekly basis when care plans were routinely reviewed and updated for patients with complex needs. However, attached healthcare staff told us that these meetings were sometimes cancelled at the last minute and there weren't always clear actions agreed and delivered as a result of these meetings.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- 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 practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

In November 2016, we identified that despite a diverse patient group, with up to 77 different language preferences, health information literature was only available in English language versions within the practice.

In this inspection, we saw the practice had produced some information to support patients to live healthier lives, in the most common language spoken by patients of the practice. For example, there was information available about bowel and breast cancer screening in multiple languages.

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Data published by NHS Digital in June 2017 showed the coverage statistics for cervical screening on a quarterly basis. (Coverage is defined as the percentage of women eligible for screening at a given point in time who were screened adequately within a specified period. This is within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). Practice data showed in 2016 quarter one, 50.9% of eligible women had been screened, quarter two 50.1% screened, and quarter three 48.4% screened.

A policy was in place to send reminder letters to patients who did not attend a cervical screening test. The practice participated in a 'pink letter' scheme with a national cancer support organisation to encourage more women to attend cervical screening. All the letters the practice sent to these patients were in English. This had not changed since the last inspection. The practice told us where a patient did not attend an appointment for screening and failed to respond to reminders, they would note this on the patient record. The next clinician who saw the patient then explained the benefit of screening services and where appropriate either carried out the screening test or rebooked them an appointment.

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.

Data from Public Health England for 2015/16 showed 24.2% of patients aged 60-69 had been screening for bowel cancer within the last 30 months. This was lower than the CCG average of 57.8% and the England average of 57.8%. Similarly, 46.2% of women aged 50-70 were screened for breast cancer in the last 36 months. This compared to a CCG average of 76.7% and an England average of 72.5%.

Inadequate

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates were in line with CCG averages. For example, childhood immunisation rates for vaccinations given to under two year olds ranged from 81.4% to 92.9% (compared to the CCG average of 64.7% to 97.1%) and for five year olds ranged from 69.1% to 97.5% (compared to the CCG average of 90.1% to 97.4%).

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

Inadequate

Are services caring?

Our findings

At our previous inspection in November 2016, we rated the practice as requiring improvement for providing caring services as the practice were generally below national averages for indicators on the National GP Patient Survey. The practice had not taken action to proactively support patients to seek or be involved in their care and treatment. They had identified a lower number of patients as carers than would be expected for the practice population.

Although the practice had made some improvements when we undertook a follow up inspection in September and October 2017. The results of the National GP Patient Survey (July 2016) were well below local and national averages. We rate the practice as inadequate for providing caring services.

Kindness, dignity, respect and compassion

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

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

The majority of the 18 patient Care Quality Commission comment cards we received were 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.

We spoke with five patients. They told us although they had concerns about access to the service, in terms of appointment availability, they were generally satisfied with the care provided by the practice and said their dignity and privacy was respected.

In November 2016, we identified the practice performed generally lower than comparators on results from the National GP Patient Survey (July 2016) with how satisfied patients were and if they were treated with compassion, dignity and respect. The practice had no plans in place to address the areas of concern raised by this survey.

In this inspection, we reviewed the results from the national GP patient survey published in July 2017. This showed the practice continued to be below comparators for patient satisfaction scores on consultations with doctors and nurses. For example:

- 68% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 62% said the GP gave them enough time compared to the CCG average of 90% and national average of 86%.
- 87% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 64% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 86%.
- 76% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 87% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.
- 74% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

The practice told us they were carrying out their own survey of patient views to help them understand and respond to areas of concern. They told us they would develop action plans once they had analysed results.

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.

However, this contrasted with the views of patients gathered through National GP Patient Survey. Results from

the National GP Patient Survey (published July 2016) relating to questions about their involvement in planning and making decisions about their care and treatment were below averages.

In this inspection, we reviewed the updated survey results, published in July 2017. These showed a continued trend of lower than average satisfaction levels with involvement in planning and making decisions about their care and treatment and results, when compared with local and national averages. From the patients who responded:

- 8.6% said the last GP they saw was poor at explaining tests and treatments (compared to a CCG average of 2.5% and a national average of 3.8%). At the other end of this scale, 72% said the last GP they saw was good at explaining tests and treatments (compared to a CCG average of 89% and national average of 86%)
- 64% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 82%.

The practice had conducted their own survey to investigate these results and was in the process of reviewing completed questionnaires.

In November 2016, we found the practice did not publicise or use the hearing loop. Information available in the practice waiting areas, informing patients of support groups and organisations was available in English language only.

In this inspection, we found the practice had a poster up informing patients there was a hearing loop available to help those with hearing impairment. There was a range of information displayed in the most commonly spoken languages by patients of the practice. This included information on how patients could access the service, and raise any concerns they had.

We also found:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- 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.
- The practice had arranged an information session at a local community service, to help inform patients from the Romanian community about the NHS, the GP service and other local health services and how to access them. The practice told us this had been well received by the community.

Patient and carer support to cope emotionally with care and treatment

In November 2016, we found the practice had identified a small number of patients who were also carers, but this was smaller than we would expect for the size and demographics of the patient population.

In September 2017, we found although this was still below the expected level of carers we would expect, indicated by the size and demographics of the patient population, it had increased from 0.3% (26 carers) to 0.6% (52 carers). The 2011 census data for the local authority area indicated that 9.1% of patients provided some level of unpaid care. The practice's computer system alerted GPs if a patient was also a carer.

We asked the practice how they ensured they met the needs of patients with caring responsibilities. They told us they had implemented a primary care navigator to whom they could refer patients who needed additional support. This included patients with caring responsibilities. (Primary care navigators help to connect vulnerable patients with care and support in the community, and provide direct non-medical support.) This was a clinical commissioning group (CCG) wide initiative.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. 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

At our previous inspection in November 2016, we rated the practice as requiring improvement for providing responsive services as the practice were generally below national averages for indicators on the National GP Patient Survey about access to the service. Information was available to patients in English language only. We identified these concerns in the December 2014 CQC inspection, but the practice had not addressed this shortfall by the November 2016 inspection.

The practice had made some improvements when we undertook a follow up inspection on 25 September 2017 and 4 October 2017. The practice did not demonstrate they were responsive to the needs of patients. There were low levels of satisfaction with access to the service and ineffective planning to support good access. The practice is now rated as inadequate for providing responsive services.

Responding to and meeting people's needs

In December 2014 and November 2016, we found information about health conditions and support organisations were available in English language only.

In this inspection, we found the practice had responded to this area of concern, and now displayed a number of information posters in the seven most common languages spoken by the practice population. These were Arabic; Bengali; Punjabi; Romanian; Urdu, and Slovak. This included information about how to access the service and also some general health information about bowel and breast cancer.

We also found

- From 4 October 2017, the practice had started to offer extended hours on a Wednesday morning from 7am to 8am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- 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.
- The practice sent text message reminders of appointments and test results.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had recently arranged an information session for the Romanian community to inform them about what services the NHS could offer, and how to access the services offered by the practice. They told us patients had fed back informally that they found this session very useful.

Patients found it hard to access services because the facilities and premises were not appropriate for the service being provided. The practice had 8,929 patients. This had increased significantly over the last three years from 7,211 in December 2014. We found the building was small and this limited the ability to respond to the need of their patients. There were three consultation and two treatment rooms. The practice recognised the limitations of the building. They were working with the local clinical commissioning group (CCG) to identify alternative premises. However, CQC had identified this issue in the two previous inspections. Discussions with the CCG and NHS England raised concerns about the practice expectations on timescales.

In the interim, the practice had not considered different ways of working to maximise the use of clinical rooms. For example, by extending the appointment times across the standard General Medical Service (GMS) contracted hours (until 6:30pm). They had not formalised escalation plans to manage risks where capacity for appointment availability was outmatched by patient demand.

Patient feedback also demonstrated low levels of satisfaction with access to appointments. There were lower levels of satisfaction with appointment availability from the National GP Patient Survey, published in July 2017. Of those who responded to the survey:

- 23% were not able to get an appointment to see or speak to someone the last time they tried. This compared with the CCG and national average of 11%.
- 30.3% said the last appointment they got was not convenient. This compared with the CCG average of 8% and a national average of 8.1%.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Of the 18 CQC comment cards we received, four raised concerns about appointment availability. We spoke with five people during the inspection and three of these raised concerns about appointment availability.

Some patients told us the way the practice worked made it difficult for them to make best use of the service offered, as it conflicted with their working commitments.

Access to the service

The practice was open between 8:30am to 6pm every Monday, Tuesday, Thursday and Friday. Every Wednesday they were open from 8:30am to 12pm and 1pm to 6pm. However, from 4 October 2017, the practice had introduced extended hours from 7am to 8am.

Appointments were available on a Monday, Tuesday, Thursday and Friday between 8:30am to 11:40am then 1pm to 5:20pm. On a Wednesday from 8:30am to 11:40am and then 2pm to 5:20pm. From 4 October 2017, extended hours appointments were offered on Wednesday mornings from 7am to 8am.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

In November 2016, we reviewed the results of the National GP Patient Survey, published in July 2016, with how satisfied patients were with how they could access care and treatment. We found these were below national and local CCG averages.

At this inspection, we reviewed the updated survey results, published in July 2017. These showed a continued trend of lower than average satisfaction levels with how satisfied patients were with how they could access care and treatment. For example:

- 73% were able to get an appointment to see or speak to someone the last time they tried. This compared with the CCG average of 84% and a national average of 84%.
- 53% said the last appointment they got was convenient. This compared with the CCG average of 81% and a national average of 81%.
- 76% of patients were satisfied with opening hours. This compared with the CCG average of 81% and a national average of 76%.
- 60% found it easy to get through to this surgery by phone. This compared with the CCG average of 77% and a national average of 71%.
- 64% described their experience of making an appointment as good. This compared with the CCG average of 74% and a national average of 73%.
- 27% felt they don't normally have to wait too long to be seen. This compared with the CCG average of 60% and a national average of 58%.

In November 2016, staff and patients told us the practice sometimes referred patients requiring urgent appointments to the local walk in service during the practices normal opening hours. At this inspection, we found the practice had not proactively addressed this by formalising agreements with other local services, such as the local walk in centre, to ensure safe escalation routes when they exceeded capacity

The practice was in the process of implementing a new technology to support increased access. This was called, Patient Partner, and provided up to four 'virtual receptionists' at any time convenient to the patient. This was planned to make access to the service by phone easier for patients.

The practice had a system to assess:

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

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.

Listening and learning from concerns and complaints

In November 2016, we saw the practice complaints leaflet was only available in an English language version.

In September and October 2017, we saw the practice had implemented some improvements. We saw that information was available to help patients understand the complaints system. For example, posters about how to make a complaint were displayed in the practice waiting area in the seven most common languages spoken by the practice patients. However, the practice complaints leaflet was still available in English language version only.

We found overall, although the practice had a system for handling complaints and concerns, the processes for listening and learning from complaints were ineffective.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

We looked at three of the 10 complaints received by the practice in the last 12 months. This demonstrated the practice did not have a fair and impartial process for listening and responding to complaints. For two examples we looked at, the same doctor to whom the complaint was about, responded to the complaint. The responses showed a lack of evidence as to how the practice took on board and learnt from complaints. In another example, when one relative complained about the attitude of the doctor, the doctor responded by apportioning blame to the patient. This necessitated a second complaint from the relative.

When the practice responded to a patient, they did not include details as to who else the patient could refer their complaint to if they remained unsatisfied.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 7 November 2016, we rated the practice as requiring improvement for providing well-led services as the vision and strategy for the practice did not support the practice in planning and implementing improvements. Although some improvements had been made since the December 2014 inspection, there were still some areas the practice had not addressed when we inspected in November 2016.

At this inspection, we found the capacity for leadership and management had deteriorated. The delivery of high quality care was not assured by the leadership, governance or culture in place. The practice is now rated as inadequate for providing well led services.

Vision and strategy

We found there was a lack of shared vision within the partnership. The practice did not have effective strategies in place to make sustainable improvements.

We saw evidence that not all partners saw the value in making financial investment to secure a good quality service and therefore it was not prioritised. This had caused disagreement between partners, and caused an impasse in making the necessary decisions, investments and improvements needed.

On review in November 2016, we found the business plan did not contain practice goals, business objectives, premises planning, workforce planning or performance goals.

Although the practice had developed a strategy and supporting business plans by this inspection. The delivery of this was at risk due to the current leadership arrangements within the practice and the ability of the practice to identify and improve those areas where they need to.

Governance arrangements

In December 2014, we rated the practice as requiring improvement overall. When we inspected again in November 2016, the practice was again rated as requiring improvement overall. At this inspection, we found the practice had not made sufficient improvements in many of the areas identified by CQC previously.

The practice overarching governance framework was not effective and did not support the practice to identify and act upon areas for improvement. This put the delivery of the strategy and provision of good quality care at risk.

- Although there was a programme of continuous clinical and internal audit, this was not effective at monitoring quality and supporting the practice to make improvements. For example, the series of significant events audits carried out did not help the practice to identify and address those events that happened more than once to reduce the risk of them happening again.
- There were arrangements for identifying, recording and managing risks and issues. However, these were not effective at supporting the practice to address the areas of concern identified and implement mitigating actions. For example, the practice had not addressed the areas of risk highlighted following a recent infection control audit. There were poor control mechanisms to manage risks where capacity for appointment availability was outmatched by patient demand.
- The practice did not have a comprehensive understanding of their own performance.
- The practice demonstrated a reactive approach to quality improvements, rather than a planned proactive approach. For example, although they reacted quickly to initial feedback from CQC on the 25 September 2017, and put in place some improvements by the time we revisited on the 4 October 2017, they had not proactively identified these concerns themselves or acted upon them when we had identified them at previous CQC inspections.

Leadership and culture

We found the capacity for leadership and management had deteriorated since the previous inspection in November 2016. There was evidence the lack of leadership and oversight in the practice resulted in ineffective systems to identify and respond proactively to emerging and knowable safety risks. There was not the management capacity in place to support the practice to improve. Some staff told us there was a lack of clear, visible leadership within the practice.

We found some areas of good practice:

Are services well-led?

Inadequate

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings or through appraisals. Minutes were comprehensive and were available for practice staff to view.

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).

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

In November 2016, we found the practice had not taken steps to ensure they encouraged and valued feedback from patients. Information about the practice's patient participation group and complaints procedures were only available in English language.

At this inspection, we found the practice had made some improvements, but further improvements were needed to ensure they received and acted upon feedback from the patient participation group.

- The practice had made attempts to initiate a patient participation group (PPG). However, only one patient had attended the last arranged meeting arranged. The practice was encouraging patients to attend and had arranged another meeting.
- The practice had carried out a patient satisfaction survey and was in the process of analysing the results.

The practice gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would give feedback and discuss any concerns or issues with colleagues and management. However, some staff commented the current management arrangements made this difficult.

Continuous improvement

There was some evidence of innovation, for example, the practice had implemented the Year of Care initiative for long term conditions. However, there was little evidence of learning or reflective working across the way the practice operated. The practice did not have effective processes in place to learn and improve the service delivered, taking into account feedback from patients, significant events, clinical audits or complaints.

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 17 HSCA (RA) Regulations 2014 Good governance 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 improve the quality and safety of the services being provided. In particular: • The governance systems in place had not supported the practice to identify areas of concern, such as the backlog of clinical correspondence and incorrect vaccine refrigerators in place, and to put in place appropriate improvement plans, until these were identified at the CQC inspection. • 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: • There were poor control mechanisms to manage risks where capacity for appointment availability was outmatched by patient demand. • There was a backlog of clerical work related to clinical correspondence because there was not enough staff to carry this out during normal working hours. The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular: • Although there was a programme of continuous clinical and internal audit, this was not effective at monitoring quality and supporting the practice to make improvements. For example, the series of

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significant events audits carried out did not help the practice to identify and address those events that happened more than once to reduce the risk of them happening again.

- The practice had not addressed the areas of risk highlighted following a recent infection control audit.

There was additional evidence of poor governance. In particular:

- The practice had failed to take reasonable steps to address some of the concerns identified at previous CQC inspections.

This was in breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have issued a warning notice in relation to this breach.