# Dr Khin Thanda

## Quality Report

Avenham Health Centre
Avenham Lane
Preston
Lancashire
PR1 3RG
Tel: 01772 401931
Website: No practice website

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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

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Dr Khin Thanda, also known as Avenham Lane Practice, on 7 December 2016. The practice was rated as inadequate for providing safe, effective, caring, responsive and well-led services and was placed into special measures for a period of six months. We also issued two warning notices in respect of safe care and treatment, and good governance. The full comprehensive report on the inspection on 7 December 2017 can be found by selecting the 'reports' link for Dr Khin Thanda on our website at www.cqc.org.uk.

This inspection was undertaken following the period of special measures and was an announced comprehensive inspection on 25 September 2017. At this most recent inspection we saw that the practice had taken steps to address some of the concerns identified at our previous inspection, however, some significant concerns remained and we also identified new concerns related to the clinical care of patients and the safe storage of refrigerated vaccines.

Overall the practice is still rated as inadequate.

Our key findings were as follows:

- We saw evidence that knowledge of and reference to national guidelines and guidance for patients' clinical care and treatment by the principal GP was lacking. Medicines were on several occasions, prescribed inappropriately.
- There was evidence that patient treatment records had insufficient details to give assurance that an adequate clinical assessment of the patient had been made and there was a lack of recording of the patient medical history and clinical signs. We saw that referrals to other services lacked detail and that there was no system in place to follow up patients who did not book appointments with services after referral.
- There was limited evidence generally of quality improvement. There was an improved system for managing significant events, however actions taken as a result of events were not reviewed. A new audit programme had been introduced although it was in its early stages and documentation of audit required improvement.

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- There was little documentation of clinical discussion and, although we saw that patient safety alerts had been addressed, there was no documentation of this and the principal GP was unaware of recent alerts.
- Systems to safeguard patients from abuse had improved since our last inspection although one practice policy to safeguard children was out of date. This was updated following our inspection.
- Records of temperatures made for refrigerated vaccines recorded temperatures over recommended levels for up to five days and the surgery had not responded appropriately to ensure patient safety. The use of loose prescription forms in the practice was not monitored.
- The practice had improved the cleanliness and hygiene of the premises since our last inspection and had introduced measures to ensure that the appropriate levels of infection prevention and control (IPC) were maintained although we saw a lack of risk assessment to assure patient and staff safety.
- The practice had failed to address the low results identified by our last inspection for the Quality and Outcomes Framework (QOF) which measured the review of patients with long-term health conditions. Results for this continued to fall (based on unvalidated figures). Low results for patient national cancer screening programmes had not been addressed and the identification of patients who were also carers was still poor.
- The practice had improved the process for working with other community and health and social care staff although we saw no evidence of care planning for vulnerable patients.
- The practice had failed to engage with patients to seek feedback on service development and delivery. As at our last inspection, there was no patient participation group and little attempt to seek patient feedback on areas for improvement. The practice still did not have a website and the practice social media page had very little information for patients. The practice had failed to address the high numbers of patients attending the local A&E department and patient concerns regarding access that were evidenced in the latest national GP patient survey.
- The practice complaints process had been improved since our last inspection and both written and verbal complaints were recorded. Patient comment cards that we received praised staff for being caring and helpful and for treating them professionally.
- We did not find that the leadership of the practice was sufficient to ensure high quality care for patients or good governance of the practice.

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.

In addition the provider should:

- Enable sufficient records to be kept for clinical discussion in meetings to allow learning to be shared.
- Improve the system for documenting quality improvement work in the practice to ensure that learning outcomes can be clearly identified and acted upon.
- Continue to improve the identification of patients who are also carers.

This service was placed in special measures in December 2016. Insufficient improvements have been made and further concerns have been identified. There remains a rating of inadequate for providing safe, effective and well led services. Therefore we are taking 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 with the Care Quality Commission.

**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.

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing safe services. We identified concerns relating to cleanliness and infection control, the management of significant events and patient safeguarding procedures. There were also concerns related to the provision of chaperones, there was no oxygen available to deal with medical emergencies and not all risks to patients had been addressed.

These arrangements had improved at this inspection on 25 September 2017, although we identified additional concerns.

- From the documented examples we reviewed, we found there was an improved system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. The documentation of events needed some improvement to clarify learning points and formal dates for review of these needed to be set. The practice also needed to review events over a period of time to identify any possible trends. When things went wrong patients were informed as soon as practicable, received support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice systems, processes and practices to minimise risks to patient safety were lacking. There was no record of actions taken as a result of patient safety alerts or recorded discussion of these, although we saw that alerts had been addressed. The principal GP was unaware of recent safety alerts. There were no risk assessments in place for the premises or staff working and the practice had not risk assessed working conditions for new staff members. There was a mercury blood pressure monitor in the practice for which there was no mercury spill kit. Also, we saw that some empty rooms were left unlocked in patient areas.
- The practice had improved systems, processes and practices in place to keep patients safeguarded from abuse although the practice policy for child protection was out of date. We were sent an updated policy following our inspection. Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.

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- The surgery was clean and infection prevention and control policies and procedures were well-managed.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Prescriptions were securely stored although the practice did not monitor the use of loose prescription forms.
- The management of refrigerated vaccines was inadequate. The practice had not addressed the high temperatures recorded for two fridges in the practice or ensured that the stored vaccines were safe.
- The practice had adequate arrangements to respond to emergencies and major incidents although these arrangements did not consider the availability of practice-specific supplies such as prescriptions.

**Are services effective?**

**Inadequate**

The practice is rated as inadequate for providing effective services.

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing effective services. We identified concerns relating to the management of patients with long-term health conditions and the lack of quality improvement work. We also found areas of staff appraisal, training and clinical knowledge to be lacking and we found concerns with the patient referral system. At this inspection, we saw that only some of these areas had been addressed, and we identified further concerns.

- The management of patients by the principal GP did not always follow best practice guidelines. Medicines were prescribed inappropriately and consultation notes were brief. We saw evidence of a lack of follow-up for patients and insufficient details in patient referrals to allow for safe assessment. Two patient referrals had been made as routine referrals when clinical information available to us indicated that they should have been urgent.
- Quality and Outcomes Framework (QOF) data that we reviewed showed that results were falling each year. Overall achievement in 2014/15 was 85% of all points available, in 2015/16, 81%, and unverified data for 2016/17 showed 74%. These results were considerably below local and national values. Patient attendance for reviews of their health conditions was poor. The practice did not have a comprehensive plan to address this.
- We saw that the locum GP had led on the practice improvement plan following our last inspection and had increased the amount of audit and quality improvement work

# Summary of findings

in the practice. However, audits were not always documented appropriately to allow actions taken as a result to be clearly monitored and acted on and this plan was still in its early stages.
- The principal GP evidenced only a basic knowledge of the Mental Capacity Act 2005 and Fraser guidelines. There was no management oversight of staff training.
- There was evidence of appraisals and personal development plans for all staff although documentation of this needed improvement to allow training needs to be better identified.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. However, the practice was unable to show us any care plans in place for patients.
- Attendance for national cancer screening programmes was below local and national averages and the practice had no plans in place to address this.

**Are services caring?**

**Requires improvement**

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

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing caring services. We found a lack of respect and consideration for patients and poor patient feedback in the national GP patient survey. At this inspection, we saw that the practice had taken some steps to address this although the results of the latest patient survey were still low.

- Results from the national GP patient survey published July 2017 showed patients rated the practice lower than that of the local and national average in some aspects of its service delivery. The practice had still not addressed these areas of concern.
- Comments that we received from patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible and available in different formats. The practice had put up posters advertising the use of a translation service for those patients who did not have English as a first language and had employed a new staff member who spoke other languages. Longer appointments were available for these patients. The practice still did not have a website.
- The practice told us that it produced care plans for vulnerable patients but was unable to evidence this.

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- The practice had a high rate of patients who did not make appointments at hospital following referrals by the practice and had no plans in place to address this.
- The practice had taken some steps to improve the identification of patients who were carers but this was still low (0.6% of the patient list).
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

**Requires improvement**

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

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing responsive services. The practice complaints system needed improving, arrangements for providing chaperones were poor and there were problems with how patients could access the practice which the practice had not addressed.

At this inspection, we found that some of these concerns had been addressed.

- There were longer appointments available for patients with a learning disability and for those with complex needs, including those who needed translation services.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice had health and social care information available for patients in the practice , however, there was no practice website and the practice online social media page had little information for patients.
- The practice had no extended hours appointments available at the time of the inspection although we were told this was to start on 2 October through a sharing agreement with other local practices. This was not advertised to patients.
- The practice had improved access for patients to chaperones. A further staff member had been trained to act as a chaperone for patients.
- The National GP patient survey showed that patient satisfaction with how they could access the practice was lower than local and national averages. The practice had not addressed this nor had they considered the high numbers of patients attending the local A&E department.

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- The practice had improved the practice complaints system and both written and verbal complaints were recorded, although the principal GP was not aware of the practice policy for dealing with complaints.

**Are services well-led?**

**Inadequate**

The practice is rated as inadequate for providing well-led services.

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing well-led services as there was inadequate governance of the practice, a lack of quality improvement and failure to engage with patients.

At this inspection, we saw little improvement in these areas.

- The practice had developed a mission statement and a succession plan.
- We continued to have concerns that the leadership lacked the necessary capability and knowledge to lead the practice effectively. Action needed to mitigate identified risks was not taken. This was resulting in risk to overall safe care and treatment of all patients.
- As with our previous inspection, at this inspection the practice failed to demonstrate that there were strong, sustainable governance arrangements in place and the clinical management of patients by the principal GP evidenced a lack of adherence to best practice guidance and guidelines. The recording of consultations for these patients was insufficient to give assurance that an adequate assessment of the patient had been made.
- There was little evidence of quality improvement. A new programme of audit activity had been introduced although it was in its early days and details of any actions taken were not always clear or recorded. Actions taken as a result of significant events were not reviewed.
- There was a lack of management oversight of staff training and no training plan in place.
- Although the practice QOF results had been falling over the last three years, there was no comprehensive practice plan in place to address this.
- Staff appraisal had been completed in a timely way although some improvements to documentation of appraisals was needed.
- There was a lack of systems and processes in the practice to protect vulnerable patients. There was no plan to address the high numbers of patients who did not book hospital appointments following referral and a lack of follow-up

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arrangements made at the practice for patients with health problems. The practice was unable to show us any care plans for vulnerable patients and there was no plan to increase the numbers of patients who attended the national cancer screening programmes. Systems to identify carers were not comprehensive.

- Arrangements for identifying, recording and managing risks were incomplete and there were no records kept of actions taken as a result of patient safety alerts.
- Procedures to keep people safe were sometimes lacking. The practice had not acted on the high temperatures of the fridges used to keep patient vaccines and the use of loose prescriptions was not monitored. The practice business continuity plan for use in an emergency was also incomplete.
- There was no practice website and patient engagement was poor; there was no patient participation group.

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## 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 requires improvement for providing caring and responsive services and inadequate for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Consultation notes on patient records we viewed had insufficient details to give assurance that an adequate assessment of the patient had been made and care and treatment did not always follow best practice guidelines. There was little evidence that follow-up arrangements for patients with health problems were made.
- Attendance for national cancer screening programmes was low. Attendance for breast screening was 33% compared to 65% locally and 73% nationally and attendance for bowel screening was 35% compared to 58% locally and nationally. The practice had no plan in place to address this.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice held multidisciplinary meetings on a monthly basis where patients with complex needs were discussed to ensure they were being cared for appropriately.
- Where older patients had complex needs, the practice shared summary care records with local care services including the out of hours service.

### People with long term conditions

Inadequate

The provider was rated as requires improvement for providing caring and responsive services and inadequate for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Systems to review patients with long-term health conditions were lacking; there was a high non-attendance of patients who were called to the practice for a health review and no comprehensive plan in place to address this.
- Data from the Quality and Outcomes Framework (QOF) showed that practice performance overall was lower than local and

national averages and was not improving. Unverified data from 2016/17 indicated that the practice had achieved 74% of points available (414.48 out of 559 points) compared to 81% in 2015/16 and 85% in 2014/15.
- The practice advanced nurse practitioner was trained in the management of patient long-term conditions and specialised in the care and treatment of diabetic patients.

**Families, children and young people**

Inadequate

The provider was rated as requires improvement for providing caring and responsive services and inadequate for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, 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. Staff knew how to report safeguarding concerns.
- Immunisation rates were relatively high for all standard childhood immunisations, however, the management of refrigerated vaccines was inadequate. The practice had not addressed the high temperatures recorded for two fridges in the practice or ensured that the stored vaccines were safe.
- Clinical staff demonstrated how children and young people were treated in an age-appropriate way and were recognised as individuals although the principal GP demonstrated a lack of understanding of best practice (Fraser) guidelines.
- The practice's uptake for the cervical screening programme was 78%, which was comparable to the CCG and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

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

Inadequate

The provider was rated as requires improvement for providing caring and responsive services and inadequate for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice did not have a website but patients could access online services through the national Patient Access system.
- At the time of our inspection, there were no extended hours appointments offered. We were told this was due to start in

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October 2017 through a sharing agreement with local practices. These appointments had not been advertised to patients and surgery opening hours on the NHS Choices website were incorrect.
- QOF results in relation to interventions and support for patients who were smokers were lower than local and national averages.
- Attendance rates at the local A&E department were high and the practice had not addressed this.
- Telephone appointments with clinicians were available in addition to face-to-face appointments.

**People whose circumstances may make them vulnerable**

Inadequate

The provider was rated as requires improvement for providing caring and responsive services and inadequate for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- We saw evidence that three patients were prescribed a particular medicine for its sedative effect and not for its intended use.
- There was a high number of patients who failed to make hospital appointments following referral by the practice and no plan in place to address this.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and those requiring more GP care such as palliative patients.
- The practice offered longer appointments for patients with a learning disability.
- The practice told us that it produced care plans for vulnerable patients but was unable to evidence this.
- The practice worked with the local nearby centre for homeless people, registering these patients to ensure that they could receive appropriate care and treatment.
- A local service worked with the practice to provide care and treatment for patients experiencing drug misuse.

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

Inadequate

The provider was rated as requires improvement for providing caring and responsive services and inadequate for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Performance for mental health related indicators was lower than average. For example, the percentage of patients with

mental health problems who had an agreed comprehensive care plan documented in their record within the preceding 12 months was 46%, compared to the local and national average of 89% (unvalidated results for 2016/17 were 58%).

- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face to face meeting in the previous 12 months was 67%, compared to the local average of 86% and national average of 84% (unvalidated results for 2016/17 were 70%).
- Clinical staff were trained in the Mental Capacity Act (MCA) and also Deprivation of Liberty Safeguards (DoLS). However, we found that the principal GP demonstrated only a basic understanding of some aspects of the MCA.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice maintained a register of patients experiencing poor mental health.

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## 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 generally performing lower than local and national averages. A total of 380 survey forms were distributed and 77 were returned (20%). This represented 2% of the practice's patient list.

- 75% of patients described the overall experience of this GP practice as good compared with the local and the national averages of 85%.
- 66% of patients described their experience of making an appointment as good compared with the local average of 72% and the national average of 73%.
- 67% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 76% 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 our inspection. We received 35 comment cards which were all positive about the standard of care received. Patients said that staff were helpful and professional and made positive comments about specific staff members. Three of the cards also had negative comments to make; two about the difficulty of getting an appointment and one about the high prescribing of antibiotics by the principal GP.

We saw three patient comments that were made on the NHS Choices website during September 2017 which praised the service provided by the practice and commented on the empathy shown by staff. This contrasted with two reviews posted in April 2017 that described staff as "rude" and lacking understanding.

## 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.

**Action the service SHOULD take to improve**

- Enable sufficient records to be kept for clinical discussion in meetings to allow learning to be shared.
- Improve the system for documenting quality improvement work in the practice to ensure that learning outcomes can be clearly identified and acted upon.
- Continue to improve the identification of patients who are also carers.

# Dr Khin Thanda

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to Dr Khin Thanda

Dr Khin Thanda's practice is a single handed GP practice and is based in a purpose built facility, Avenham Lane Health Centre in Avenham Lane, Preston, PR1 3RG. The building also accommodates community health services. The practice is part of Greater Preston Clinical Commissioning Group and all services are delivered under a General Medical Services (GMS) contract.

Dr Khin Thanda is supported by one male long-term locum GP who has been with the practice for more than six years. The GPs work 2.5 days each and are supported by an advanced nurse practitioner (ANP) who works for 20 hours each week. The practice has three administrative and reception staff who are led by the part -time practice manager.

The surgery is open to patients between 8.30am and 6pm on weekdays and appointments are offered from 9am to 11.30am and 4pm to 6pm. Appointments on Thursday afternoons are for emergencies only. Patients can telephone the surgery from 8am in the morning and between 6pm and 6.30pm when telephone access to the practice is diverted to a mobile telephone number. When the practice is closed patients are advised to contact NHS 111. Out of hours service is provided by GotoDoc Ltd., based at Preston hospital.

Patients can book appointments in person, via the telephone or online through the national Patient Access service. The practice provides telephone consultations, pre-bookable consultations, urgent consultations and home visits.

The practice has car parking immediately outside the building, with clearly marked disabled spaces. There are accessible toilets in the community health centre which patients visiting the practice can use. All patient facilities are located at ground floor level. The practice has a reception and waiting area, two GP consulting rooms and a nurse treatment room with further administrative areas.

The practice provides services to 3425 registered patients. Data shows the practice population is made up of a higher proportion of patients aged under 18 years compared to the national average (24% compared to 21%) and fewer patients aged 65 years and over than nationally (5% compared to 17%).

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest. There are 49% of patients with a long-standing health condition; lower than the national average of 53%. The practice has a higher percentage of unemployed patients compared with the national average; 18% compared with 4%.

## Why we carried out this inspection

We carried out a comprehensive inspection of Dr Khin Thanda on 7 December 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for

providing safe, effective, caring, responsive and well-led services and was placed into special measures for a period of six months. We also issued two warning notices in respect of safe care and treatment and good governance.

The full comprehensive report on the inspection on 7 December 2017 can be found by selecting the 'reports' link for Dr Khin Thanda on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of Dr Khin Thanda on 25 September 2017. This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice could come out of special measures.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 September 2017. During our visit we:

- Spoke with a range of staff including the principal GP, the locum GP, the advanced nurse practitioner, the practice manager and two members of the practice administration team.
- Observed how staff interacted with patients 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 with dementia).

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

Inadequate

# Are services safe?

## Our findings

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of cleanliness and infection control were not adequate. There was no comprehensive process for the management of significant events and insufficient patient safeguarding procedures. There were also concerns related to the provision of chaperones and there was no oxygen available to deal with medical emergencies. Not all risks to patients had been addressed.

These arrangements had improved when we undertook a follow up inspection on 25 September 2017, although we identified some further concerns and the practice is rated as inadequate for providing safe services.

**Safe track record and learning**

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available in the practice reception area. 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 four 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 support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. Significant events had been added as a standing agenda item for whole practice meetings. The practice carried out an analysis of the significant events although learning points from events were not always clear and comprehensive. There were no formal dates for review of actions taken; the practice recorded "ongoing" for review dates and had not yet carried out an annual review of events, although they told us that they planned to do this in April 2018. We also saw that serious incidents were not always reported as significant events, such as the failure of the practice refrigerators to store vaccines appropriately. The practice had failed to respond to this incident appropriately and had not followed best practice process and procedure.
- There was no formal record of actions taken as a result of patient safety alerts or changes to clinical guidelines and no record of discussion of these although we were told that this happened. We saw that action had been taken in respect of safety alerts and changes in national guidelines although the principal GP who we spoke to was unaware of known recent patient safety alerts.

**Overview of safety systems and process**

The practice had improved systems, processes and practices in place to minimise the risks associated with patient safeguarding.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff in a folder in the reception office although one policy related to protecting children was out of date. The practice sent us an updated policy following the inspection. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare and there were contact telephone numbers displayed on reception office and treatment room walls. The principal GP was the lead member of staff for safeguarding. From the documented example that we reviewed, we saw evidence safeguarding procedures were implemented appropriately.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and all had received training on safeguarding children and vulnerable adults relevant to their role. The GPs were trained to child protection or child safeguarding level three as was the advanced nurse practitioner.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice, since our December 2016 inspection, had increased chaperone provision in the practice by training a

member of administrative staff. This staff member worked in the practice for 34 hours a week and so was usually available when the nurse was not in practice. We were told that further staff would be trained to increase provision in the future.

The practice had improved standards of cleanliness and hygiene since our last inspection.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. The practice had increased cleaning services and purchased new blinds in all areas of the practice.
- The advanced nurse practitioner was identified as the infection prevention and control (IPC) lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. An IPC audit had been undertaken since our inspection in December 2016 and we saw evidence that action had been taken to address improvements needed as a result. The local authority IPC specialist nurse had assisted the practice to achieve good standards of cleanliness and hygiene.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not mitigate all of the 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. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Prescription pads were securely stored and there were systems to monitor their use, however, although loose prescription forms were stored securely there was no system in place to monitor their use. The advanced nurse practitioner had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the GPs for this extended role.
- We saw that refrigerated vaccines in the practice were kept in two fridges. Practice protocol allowed for these fridges to be monitored daily to check that temperatures did not go outside the acceptable range required to keep medicines safe for use. When the advanced nurse practitioner was not in the practice, a member of the administration staff completed the monitoring records. We saw records for the practice main fridge that indicated that the maximum temperature on a Thursday, Friday and the following Monday had exceeded acceptable levels. When we asked the nurse about this, she told us that she had contacted the manufacturer on the Monday in question to find out how to reset the temperature settings. She had not followed the procedure indicated when temperatures were outside the accepted range which was advertised on the outside of the fridge. She also told us that she believed that the administrative staff member had removed all vaccines on the Thursday and stored them in the practice smaller, second fridge. When we asked the practice manager about this, they told us that they had no knowledge of any incident related to the fridge; no incident had been reported or vaccines removed. We also saw that the practice second "overflow" fridge had maximum temperatures recorded for the previous two days that exceeded the acceptable range. The practice told us that they were aware that there were sometimes problems with the temperature of this fridge and did not use it to store vaccines. However, we saw 20 'flu vaccines in this fridge. We asked the practice to follow procedure and contact NHS England to report these incidents. We were made aware two days after the inspection that this had not been done and the Vaccination and Immunisation department at Public Health England told us that they would contact the practice immediately. On the day of inspection, the practice ordered two data loggers for use in the fridges so that temperatures could be continuously monitored in the future.

We saw that the practice operated a clean desk policy and that there was no patient information visible, although some empty rooms that could be accessed by patients were not locked and the principal GP left her computer access card in the machine when she left the room.

We reviewed the personnel file for a new staff member employed since our previous inspection in December 2016 and found that appropriate recruitment checks had been

undertaken prior to employment. For example, proof of identification, references, qualifications, and the appropriate checks through the Disclosure and Barring Service.

The practice recruitment policy said that the practice would ascertain any relevant information about physical or mental conditions that related to staff ability to perform regulated activities. However, no confidential health questionnaire had been used to risk assess working conditions for the new staff member.

**Monitoring risks to patients**

There were procedures for assessing, monitoring and managing risks to patient and staff safety although these were not always comprehensive.

- There was a health and safety policy available and a poster displayed in the reception office.
- The practice maintained an overview of building and equipment safety checks and when they were next due. There were electrical and gas safety certificates available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. 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. We found a blood pressure monitor that had been checked and that contained mercury in one of the doctor's rooms. The GP told us that they used it for some patients. There was no mercury spill kit available to deal with accidental mercury spillage which could be harmful to staff or patients. The practice told us that they would safely dispose of it as soon as possible.
- 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). All necessary actions were being taken to mitigate the risks of legionella in the water system.
- Although there were general risk assessments arranged for the building by the management company, the practice had not carried out any risk assessments for the premises or for staff working conditions.
- 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. Staff told us that they were able to cover staff absence safely.

**Arrangements to deal with emergencies and major incidents**

The practice had 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.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available. The practice had introduced regular checks of emergency equipment to ensure that it was always fit for use and that oxygen was always 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 business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. These arrangements mainly relied on using a neighbouring practice if the premises became unavailable, however, consideration had not been given in the plan to the availability of practice-specific supplies such as prescriptions.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing effective services. We found that the management of patients with long-term health conditions was insufficient, there was a lack of clinical audit or quality improvement work, no regular staff appraisal and a lack of staff training in some areas. We also found that there was no management oversight of staff membership of professional bodies or medical indemnity and that knowledge of the Mental Capacity Act by the principal GP was limited. There were also shortcomings in the referral system for patients.

When we inspected the practice on 25 September 2017, we found that these arrangements had improved in some areas, however, we found that there had been no improvement in others and we identified further concerns. The practice is still rated as inadequate for providing effective services.

**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 these to update practice clinical policies and procedures.

However, looking at the practice computerised clinical system we saw that care and treatment was not always provided to patients in line with NICE guidelines and current evidence-based standards. We looked at 16 random patient consultations by the principal GP at the surgery during the month of September 2017 and found that 13 of them evidenced that treatment had not followed best practice guidelines for the management of patients, four of them in the prescribing of antibiotics. Details recorded for all consultations were brief and 10 records lacked any history of a detailed examination being carried out. We saw evidence of a lack of follow up and safety netting procedures for patients and evidence that patient referral letters to hospital were brief and contained insufficient detail to enable the referral to be assessed appropriately. Two referrals were made as routine referrals where possible two week wait (urgent) referrals were indicated based on the clinical information available and one referral had been made to Orthopaedics instead of Orthoptics.

When we asked regarding the recording of clinical details on patient notes, we were told that the GP knew the patients and so only recorded significant findings. We also asked about the reason for not following guidelines for the prescribing of antibiotics. We were told that different antibiotics were given as patients did not like the taste of the recommended medicines and that antibiotics used to treat bacterial infections were sometimes prescribed, even for known viral infections, because patients expected it.

We also noted that some surgeries were very busy with the average time for each patient being just over five minutes. We saw one surgery of two hours and 39 minutes where 27 patients had been booked to attend. This impacted on the amount of time available to consult with patients and record findings on 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 recently published results for 2015/16 showed the practice achieved 81% of points available (451.67 out of 559 points) with overall exception reporting of 12%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This overall QOF achievement was 13% lower than the clinical commissioning group (CCG) average and 12.5% lower than the national average. This was also slightly lower than the previous year's achievement for the practice, which for 2014/15 was 85% of available QOF points.

We were shown unvalidated evidence by the practice for QOF results for 2016/17 which indicated that the practice had achieved 74% of points available (414.48 out of 559 points). We were also shown unvalidated data that showed

Inadequate

# Are services effective?

## (for example, treatment is effective)

that, based on data for the year prior to the 20 September 2017, the practice was achieving 71% of points available. The practice was unable to give us any data regarding exception reporting for these unvalidated figures.

Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to CCG and national averages in six of the 11 care indicators. Other indicators were either in line with or below CCG and national averages and some of these had higher levels of exception reporting. For example, the percentage of patients with diabetes on the register in whom the last blood pressure reading was 150/90, was 92% compared with the CCG average of 91% and national average of 91% (unvalidated results for 2016/17 were 89%). The percentage of patients with diabetes, on the register, whose last measured total cholesterol was 5 mmol/l or less was 81% compared with the CCG average of 78% and national average of 80% (unvalidated results for 2016/17 were 78%). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 59 mmol/mol or less in the preceding 12 months was 57% compared to the CCG average of 71% and national average of 70% (unvalidated results for 2016/17 were 60%). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months was 68% compared to the CCG average of 78% and national average of 78% (unvalidated results for 2016/17 were 68%).
- Performance for mental health related indicators was lower than the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had an agreed comprehensive care plan documented in their record within the preceding 12 months was 46%, compared to the CCG and national averages of 89% (unvalidated results for 2016/17 were 58%). The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of alcohol consumption in the preceding 12 months was 66% compared to the CCG and national averages of 89% (unvalidated results for 2016/17 were 56%). The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face to face meeting in the previous 12 months was 67%, compared to the CCG average of 86% and national average of 84% (unvalidated results for 2016/17 were 70%). We noted that the practice exception reporting rate for this intervention was 25%, which was 20% higher than the CCG average and 18% above the national average.
- Performance for care indicators for people with respiratory illnesses (chronic obstructive pulmonary disease; COPD) was higher than local and national averages but with higher rates of exception reporting. For example, the percentage of patients with COPD in whom the diagnoses had been confirmed by spirometry between three months and 12 months of entering onto the disease register was 92%, compared to the CCG average of 86% and national average of 89% (unvalidated results for 2016/17 were 50%). However, the rate of exception reporting for this care indicator was 37%, which was 24.5% higher than the CCG average and 28% above the national average. The percentage of patients with COPD who had undergone a review with a healthcare professional including an assessment of breathlessness in the preceding 12 months was 100%, compared to the CCG average of 87% and national average of 90% (unvalidated results for 2016/17 were 74%). However, the rate of exception reporting for this care indicator was 29%, compared to the CCG average of 14.5% and national average of 11.5%. The percentage of patients with COPD who received an influenza immunisation in the preceding 1 August to 31 March was 100%, compared to the CCG average of 97% and national average of 97% (unvalidated results for 2016/17 were 92%). The rate of exception reporting for this care intervention was 37%, compared to the CCG average of 21% and national average of 18%.

Following our inspection in December 2016, the practice had introduced discussion of the QOF as a standing agenda item in practice team meetings, however, we saw nothing in meeting minutes to suggest that action had been taken to address these falling results. On our inspection, we were told that many patients did not attend for booked appointments or did not respond to invitations to attend the practice for a review of their health condition. Staff we spoke to were unable to detail any plans in place to address this other than ensuring that records accurately recorded that patients had failed to attend for an appointment and ensuring that diary dates were set in an effort to aid patients being contacted in a timely way. The advanced nurse practitioner (ANP) invited patients to attend for reviews of patient long-term health conditions.

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# Are services effective?

## (for example, treatment is effective)

There was no dedicated time for this although patients failing to attend for appointments allowed for capacity to carry this out. The ANP told us that there was no administrative staff resource available to produce patient invitations. We were told by the practice that the ANP preferred to carry out the call and recall of patients herself as she had detailed knowledge of the patients.

There was the equivalent of one whole-time equivalent GP for the practice list size of 3,425 patients at the time of our inspection and the ANP was employed for 20 hours each week.

There was no evidence of audit or quality improvement work undertaken by the practice to improve QOF results or improve systems to engage patients in attending the practice for reviews of their health conditions.

Following our inspection in December 2016, the practice locum GP had worked on implementing quality improvement projects within the practice including clinical audit. We saw evidence of quality improvement with whole team involvement although, as this was new work, most topics were planned for re-audit in the future to assess the effectiveness of any interventions. We noted that audits were documented however, there was a lack of a formal, recommended format for these to enable an action plan to be easily identified and actions needed to produce quality improvement were not always identified. For example, the practice had audited patient referrals that had been returned to the practice and had found that 23 of them were due to patients not contacting the booking service to book their appointment and 13 were due to insufficient information on the referral letter. There was no clear action plan recorded to address this.

Information about patients' outcomes were used to make improvements such as ensuring that all diabetic patients were being managed appropriately in line with best practice guidelines and were being prescribed the appropriate medication. The practice planned to call all patients identified by the audit as needing a medication review to the practice for a consultation with a GP.

**Effective staffing**

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment. The principal GP evidenced a lack of knowledge in some areas of clinical care. However:

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The ANP had trained to initiate insulin for diabetic patients and, together with a colleague, was training other nurses in this. The ANP had also started an interest group in the evenings for clinicians with an interest in diabetes, and practice and hospital nurses and pharmacists attended this.
- 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 and local meetings.
- Since our last inspection in December 2016, all staff had had an appraisal which allowed for any training needs to be identified. Staff told us that access to appropriate training to meet learning needs was sometimes difficult, for example chaperone training. Staff had trained in infection prevention and control (IPC) since our last inspection which had been delivered by the local IPC lead nurse. The practice had also introduced a whistle-blowing policy which staff were aware of. Records of staff training were kept in individual staff files although there was no management oversight of training that had been completed or when that training needed to be repeated. The ANP told us that they had ongoing support, one-to-one meetings, coaching and mentoring from the GPs. They said that there was clinical discussion and peer review between staff although this was not recorded.
- Staff had received training that included safeguarding, basic life support and information governance. Staff had access to and made use of some e-learning training modules and in-house and external training.

**Coordinating patient care and information sharing**

Inadequate

# Are services effective?

## (for example, treatment is effective)

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 were told that this included care and risk assessments, care plans, medical records and investigation and test results, however, the practice was unable to show us any care plans in place for patients. Staff told us that they were aware that better care planning for patients was needed.
- From the examples we reviewed we found that the practice did not always share relevant information with other services in a timely way, for example when referring patients to other services. Some referrals by the principal GP lacked detail and we saw two referrals that had been made routinely when clinical information available indicated that they should have been urgent.
- The practice shared information with the out of hours service regarding patients nearing the end of their lives. This included when a do not attempt cardiopulmonary resuscitation (DNACPR) order was in place.

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. However, we saw that consultations by the principal GP lacked sufficient detail to make these records effective . Meetings took place with other health and social care professionals on a monthly basis to review patient care and treatment for patients with complex needs.

### Consent to care and treatment

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

- Staff generally understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Clinical staff were generally aware of relevant legislation when patients were under the age of 16 years such as the Gillick competency and Fraser Guidelines. (Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent and to help assess whether a child has the maturity to make their own decisions). Since our last inspection, clinical staff had trained in the MCA and also Deprivation of Liberty Safeguards (DoLS). However, we found that the principal GP still demonstrated a lack of understanding of some aspects of the MCA and Fraser guidelines.
- 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.

### Supporting patients to live healthier lives

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 and patients experiencing memory loss. Patients were signposted to the relevant service.
- Smoking cessation advice was available from a local support group as well as from clinicians in the practice. However, information recorded on the QOF indicated that only 48% of current smokers had been offered support and 72% of those with chronic disease had been given advice on stopping smoking (unverified data for 2016/17).

The practice's uptake for the cervical screening programme was 78%, which was comparable to the CCG and the national average of 81%. There was a policy to offer written reminders for patients who did not attend for their cervical screening test. The practice 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 told us that they encouraged patients to attend national screening programmes for bowel and breast cancer although attendance at these programmes was lower than local and

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# Are services effective?

## (for example, treatment is effective)

national averages. Attendance for breast screening was 33% compared to 65% locally and 73% nationally and attendance for bowel screening was 35% compared to 58% locally and nationally.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccinations given in 2015/16 were higher than the national expected coverage of 90%. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 95% coverage and there was 96% coverage for immunisations given to under one year old children.

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 although we were told that patients did not always attend these appointments. This had been the case when we last inspected in December 2016 and the practice had not introduced any plans to address this.

Requires improvement

# Are services caring?

## Our findings

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing caring services as we had observed staff talking about patients in a derogatory manner and we found a lack of information available for patients who did not have English as a first language. We also found that results from the national GP patient survey were less favourable than local and national averages and that only 14 patients had been recognised as carers.

We found that some of these concerns had been addressed when we undertook a follow up inspection on 25 September 2017 and the practice is rated as requires improvement for providing caring services.

**Kindness, dignity, respect and compassion**

During our inspection we observed that members of staff were courteous and 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.

At our last inspection, we only received two Care Quality Commission (CQC) comment cards. At this inspection, all of the 35 CQC patient comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Three of the cards also had negative comments, two about the difficulty in getting an appointment and one about the high prescribing of antibiotics by the principal GP.

We saw three patient comments that were made on the NHS Choices website during September which praised the service provided by the practice and commented on the empathy shown by staff. This contrasted with two reviews posted in April that described staff as "rude" and lacking understanding.

The national GP patient survey was published in July 2017. The practice was generally lower than average for its satisfaction scores on consultations with GPs and nurses. For example:

- 76% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) and the national averages of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 86%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 86%.
- 89% of patients said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 85% of patients said the nurse gave them enough time compared with the CCG and the national average of 92%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 80% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and the national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

We asked the practice if they were aware of the results of this survey and were told that they were not. Staff told us that the practice placed little credence on the results of the GP patient survey. We had noted at our last inspection on 7 December 2016 that the practice had reviewed the results of the national patient survey that were published on the 7 July 2016 and had not addressed the results which were similar to the latest national survey. The practice had conducted its own patient survey of 29 patients in September 2017 but questions were very limited, not related to the GP patient survey and the practice had not addressed any of the negative comments made by patients.

Requires improvement

# Are services caring?

**Care planning and involvement in decisions about care and treatment**

Patients' comments left on the CQC comment cards 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 were given enough information to make an informed decision about the choice of treatment available to them. The practice told us that they encouraged patients to make longer appointments if they had complex needs and we saw surgeries on the practice computer system that confirmed this.

The practice told us that they produced care plans for vulnerable patients but were unable to evidence this. They also told us that this was an area of patient care that they wanted to improve.

Results from the latest national GP patient survey showed patients generally responded similarly to CCG and national averages when asked about their involvement in planning and making decisions about their care and treatment. For example:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.
- 89% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. Since our last inspection in December 2016, the practice had advertised this widely on posters in the practice and had employed a new staff member who was able to speak other languages.
- Information leaflets were available in easy read format.
- The NHS e-referral system was used with patients as appropriate. (The NHS e-referral system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). We saw that the practice had audited referrals that were returned to the practice for patients who had failed to engage with this service although the practice had no plans in place to deal with this problem.
- There was a hearing loop in the practice reception area for patients with impaired hearing.

**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. The practice did not have a website although since our last inspection it had introduced a page on a social media site. We saw that the page had been started on 11 April 2017 and there had been one post by the practice about practice closures during the Easter period, made on 12 April 2017. There was little information for patients on the site and the practice told us that they were getting support from the CCG computer support unit in the near future to develop it further. 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. At our last inspection in December 2016, we found that the practice had identified 14 patients as carers (0.4% of the practice list). The practice had added a question to the practice questionnaire for new patients to ask whether they were a carer and at this inspection we saw that they had identified 19 patients as carers (0.6% of the practice list). Written information was available to direct carers to the various avenues of support available to them and all were invited for an annual flu vaccination.

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.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

At our previous inspection on 7 December 2016, we rated the practice as inadequate for providing responsive services as the arrangements in respect of recording, investigating and learning from complaints needed improving, arrangements for providing chaperones were poor and there were problems with how patients could access the practice which the practice had not addressed.

These arrangements had improved when we undertook a follow up inspection on 25 September 2017 and the practice is now rated as requires improvement for providing responsive services.

**Responding to and meeting people's needs**

The practice had taken steps to understand its population profile and had used this understanding to try to meet the needs of its population:

- There were longer appointments available for patients with a learning disability and for those with complex needs, including those who needed translation services.
- 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 results of these conversations were shared with the practice out of hours service.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- There was no practice website available and the practice online social media page had little information for patients.
- A podiatrist visited the practice twice a month to provide care for diabetic patients.
- The practice had improved access to chaperones since our last inspection and a trained chaperone was easily available to avoid the need for patients to rebook appointments.
- The practice worked with the local nearby centre for homeless people, registering these patients to ensure that they could receive appropriate care and treatment.
- Midwives visited the practice weekly to offer patients antenatal services.
- A local service worked with the practice to provide care and treatment for patients experiencing drug misuse.
- Patients experiencing mental health problems were able to be referred directly to a local mental health service.
- There were other services in the building for patients including family planning, a weekly phlebotomy clinic (for taking patients' blood), a treatment room service to treat minor illness, a tuberculosis clinic and a service offering termination of pregnancy.

**Access to the service**

The surgery was open to patients between 8.30am and 6pm on weekdays and appointments were offered from 9am to 11.30am and 4pm to 6pm. Appointments on Thursday afternoons were for emergencies only. Patients could telephone the surgery from 8am in the morning and between 6pm and 6.30pm when telephone access to the practice was diverted to a mobile telephone number. The practice told us that they had only had two calls to the mobile in the last seven weeks, one to check practice opening times and one to order a prescription. We were told that the patient ordering the prescription was asked to ring back the following day, although the practice leaflet indicated that prescriptions could be ordered at this time. At the time of our inspection, no extended hours appointments were offered to patients, however, there were plans to offer these from the 2 October 2017 using an arrangement between local practices. The practice did not have a website and opening times were advertised to patients through the NHS Choices website. The opening times on the NHS Choices website showed that the practice was closed on Thursday afternoons and did not advertise that extended hours appointments would be available. We saw that the next pre-bookable appointment with a GP was available five working days following the day of our inspection although the practice had a system to release most appointments for booking on the same day.

Patients were able to book appointments online through a national online booking system. This was advertised to patients in the practice by leaflets in the patient areas.

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

Results from the national GP patient survey of July 2017 showed that patient's satisfaction with how they could access care and treatment was generally lower than local and national averages.

- 67% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 65% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 71%.
- 66% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG and the national averages of 84%.
- 69% of patients said their last appointment was convenient compared with the CCG and the national averages of 81%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 75% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 60% and the national average of 58%.

The practice had not considered these results in relation to patient access to the practice. At our last inspection, we saw that figures for patients attending the local accident and emergency department were high and reported that the reasons for this had not been investigated by the practice. At this inspection, we found that this still had not happened although these rates remained high.

The practice had a system to assess:

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

Staff recorded patient requests for home visits and passed them to the GPs who telephoned patients or their carers before they visited. 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**

The practice had a system for handling complaints and concerns. Following our last inspection in December 2016 when we found this system to be ineffective, the practice had reviewed and revised its complaints policy and had started to record verbal complaints. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We asked the principal GP if patients received an apology when they made a complaint and they told us that only written complaints received a written apology. This was not in line with the practice complaints policy and we saw a written apology that had been made in response to a verbal complaint.

- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There were complaints posters displayed in the patient waiting area and reception and copies of the practice complaints procedure available for patients in reception.

We looked at two complaints received in the last six months and found they had been dealt with in a timely way and with openness and honesty. Both written and verbal complaints were recorded. For example, following a patient complaint regarding the lack of online access to appointments, the practice sent the patient a leaflet explaining the process and details of how to register for the service and offered an apology for the difficulties that had been experienced when booking an appointment.

# 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 December 2016, we rated the practice as inadequate for providing well-led services as there was no vision or strategy for the practice, no comprehensive governance structure and no practice quality improvement plan. The practice had failed to engage with patients with regard to existing services and any future plans for service development.

We issued a warning notice in respect of these issues and found that although some improvement had been made when we undertook a follow up inspection of the service on 25 September 2017, we identified additional concerns. The practice is still rated as inadequate for being well-led.

**Vision and strategy**

The practice mission statement was to:

"provide quality health services and facilities for the practice population"

"participate in the creation of healthier lives within the community"

"build a supportive team and environment for patients, employees and clinical staff"

"strive to deal with all patients in a professional and polite manner"

The practice had worked with the local medical committee to produce a succession plan although this was not formally recorded.

**Governance arrangements**

As at our previous inspection the practice failed to demonstrate that there were strong governance arrangements in place.

We found that issues that affected the delivery of safe and effective care had not been identified or adequately managed.

- The clinical management of patients evidenced a lack of adherence to best practice guidance and guidelines, and clinical recording of consultations for these patients was insufficient to give assurance that an adequate assessment of the patient had been made. The principal GP told us that she did not record detail as she knew the patients well. There were a high number of patients who did not book appointments with hospital services following referral by the practice and this had not been addressed. Although we saw that recent patient safety alerts had been circulated and actioned by the practice, the principal GP was unaware of the most recent of these. There was a lack of care planning for patients.
- Adverse incidents in the practice were not always treated as significant events, such as the failure of the cold chain in the refrigeration of vaccines. Also, there were no review dates for actions taken as a result of significant events or review of events to identify any possible trends.
- Although the practice QOF results had been falling over the last three years, there was no comprehensive practice plan in place to address this.
- There was no management overview of staff training or training plan in place to allow for timely completion of training.
- Practice specific policies were implemented and were available to all staff on the practice shared computer drive or in hard copy. The child protection policy was out of date and the practice sent us an updated policy following our inspection.
- An understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. However, there was no quality improvement plan in place to address deficiencies in service delivery. We saw evidence of audit activity in the practice but there was no clear record of actions taken to implement improvements.
- Arrangements for identifying, recording and managing risks were incomplete. There were no risk assessments in place for the practice environment or staff working and no confidential health questionnaires used to risk assess working conditions for new staff. The practice manager was unaware that there was a mercury-based blood pressure monitor in the practice and doors to empty rooms in patient areas were sometimes left unlocked. We saw that the business continuity plan was incomplete and did not allow for the availability of practice-specific documents such as prescriptions. There was also no policy in place to address the safety of GP sessions that could be very long.

**Leadership and culture**

On the day of inspection the principal GP and practice manager failed to demonstrate they had the experience,

# Are services well-led?

Inadequate

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

capacity and capability to run the practice and ensure high quality care. Although they told us they prioritised safe, high quality and compassionate care, evidence gathered through inspection did not support this. The locum GP had led the practice improvement plan following the last inspection in December 2016.

The provider was generally 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). The GPs told us that they encouraged a culture of openness and honesty although the principal GP was not clear as to the practice policy with regard to the duty of candour. From the sample of two 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.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social care workers to discuss vulnerable patients. GPs, where required, met or communicated with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings and these meetings were minuted. However, although we were told that discussions between clinicians took place, these tended to be ad hoc and were not minuted. There were standing agenda items for practice meetings although these were not comprehensive and there was no record of discussion of patient complaints, patient safety alerts or clinical guideline changes.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

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

The practice was unable to evidence that it valued feedback from patients. It sought feedback from patients with short, internal surveys of patient opinion but failed to address any areas of the service that were criticised or indicated as requiring improvement. The national patient survey that was completed by a larger proportion of practice patients was not considered, nor was there any discussion of those areas indicated as needing improvement.

The practice had failed to establish a patient participation group (PPG). They advertised the group on a poster in the patient waiting area and used posters to announce a meeting for patients that anyone could attend. No patients attended the meeting. There was no practice website to encourage membership and the practice had not considered alternative ways to obtain patient feedback, for example through the new patient questionnaire.

**Continuous improvement**

There was a lack of focus on continuous learning and improvement at all levels within the practice save that demonstrated by the locum GP.

The practice was working with other practices in the locality to provide extended hours appointments and services that could be offered using this group model of care for patients.

The locum GP told us that he planned to work with other local services and organisations to improve patient care, for example, work with the local mosque to improve the uptake of cervical smears. He told us that he wanted to improve clinical governance and quality improvement within the practice.

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<br>Maternity and midwifery services<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The practice must comply with Regulation 12(1).<br><br>Care and treatment must be provided in a safe way for service users 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.<br><br>**How the regulation was not being met:**<br><br>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:<br><br>· Care was not always delivered in line with national guidelines and guidance.<br>· Patient treatment records had insufficient details to give assurance that an adequate assessment of the patient had been made and there was a lack of recording of the patient medical history and clinical signs.<br>· The review of patients with long-term conditions was not conducted in a timely way.<br>· Patient details were not always shared with other services appropriately.<br>· Refrigerated vaccines were not managed according to best practice guidelines to ensure patient safety. |

This section is primarily information for the provider

# Enforcement actions

· Patient care plans were not used to ensure co-ordinated, proactive care for vulnerable patients.

· The registered person did not do all that was practicable to proactively seek initiatives that could potentially increase the uptake of national breast and bowel screening programmes.

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<br>Maternity and midwifery services<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The practice must comply with Regulation 17(1).<br><br>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.<br><br>**How the regulation was not being met:**<br><br>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:<br><br>· There was little evidence of quality improvement work. Audit was in place but findings were not acted on.<br><br>· The process to prevent significant events re-occurring was insufficient.<br><br>· There was no comprehensive engagement with patients and results from patients surveys were not addressed. |

This section is primarily information for the provider

# Enforcement actions

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

· The practice did not have comprehensive premises and staff working risk assessments in place. Some empty rooms were left unlocked in patients areas.

· The practice failed to monitor the use of loose prescriptions and had not considered the need for provision of necessary documents such as prescriptions in the event of service disruption.

· There was a lack of management oversight of staff training and no training plan.

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