# Springfield House

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

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

We carried out an announced comprehensive inspection at Springfield House on 30 September 2016. Overall the practice is rated as inadequate.

The practice had been previously inspected on 18 March 2015. Following that inspection the practice was rated as requires improvement with the following domain ratings:

Safe – Inadequate

Effective – Requires improvement

Caring – Good

Responsive – Good

Well led – Requires improvement.

The practice provided us with an action plan detailing how they were going to make the required improvements. In addition, they wrote to us on 2 August 2016 to confirm all the required actions had been addressed.

The inspection on 30 September 2016 was to confirm the required actions had been completed and award a new rating if appropriate.

Following this re-inspection on 30 September 2016, our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example recruitment checks on staff did not ensure they were of good character, fire safety checks were not adequate and there was no health and safety risk assessment.
- Non-clinical staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with all staff. Not all incidents were reported appropriately.
- Information about how to complain was available but not all complaints were appropriately investigated or responded to.

# Summary of findings

- Training was not well monitored and there was no evidence of all staff completing appropriate training.
- Not all staff were aware of who their line manager was and performance appraisals had not been carried out for over a year.
- Extended hours opening was not available.
- GPs carried out audits and there was evidence of quality improvement following clinical audit cycles.
- There was a patient participation group (PPG) which told us the practice listened to their ideas.

The areas where the provider must make improvements are:

- The provider must introduce effective governance procedures. These must include processes for reporting, recording, acting on and monitoring significant events, incidents and near misses, investigating and responding to complaints, ensuring all medical equipment is within its expiry date and assessing the performance of non-clinical aspects of the practice, making improvements where issues are identified.
- The provider must ensure all relevant training for staff is completed and training is monitored so it can be repeated at appropriate intervals.
- The provider must review chaperone procedures to avoid embarrassment to patients. In addition they must ensure access to appointments is available for patients under the age of 16 who have the appropriate level of competence and wish to attend without a parent or guardian.
- The provider must ensure all recruitment checks are in place to ensure staff are of good character.
- The provider must assess the health and safety of patients and staff at the practice and take action where issues are found. This includes having fire safety assessments and checks in place.

The areas where the provider should make improvement are:

- The provider should improve access to health checks for patients aged 40 to 75 and the over 75 age group who are not in care homes.
- The provider should have a system in place to improve their identification of carers and offer more formal support to carers.
- The provider should review their arrangements for home visits so patients in need of urgent medical attention are easily identified.
- The provider should provide up to date appraisals for staff.

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

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

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Inadequate

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

- Not all staff were clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated to all staff. Not all significant events were recorded so they could not be appropriately investigated.
- Patients were at risk of harm because systems and processes were not in place or had weaknesses. For example, not all relevant checks were carried out prior to employing new staff and on-going checks, such as ensuring clinicians had up to date professional registration, were not carried out.
- Although staff told us checks were in place we found several out of date items including medical instruments five years past their expiry date. Other equipment was perished and not functional.
- There was insufficient attention to safeguarding children and vulnerable adults. Not all staff understood safeguarding and not all had been trained.
- Although a fire risk assessment had been carried out by the practice risks had not been identified and checks were not carried out to keep people safe.

**Are services effective?**

Inadequate

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

- Training was not well monitored and we saw that not all staff, including those working at the practice for several years, had completed mandatory training.
- Staff appraisals had not been carried out for over a year, with the last recorded date for some appraisals being over four years ago. Some staff did not know who their line manager was.
- Although clinical staff were aware of the Mental Capacity Act 2005 and the Gillick Competence, we were told by the practice manager that a parent or guardian needed to be present when an appointment was booked for a young person under the age of 16.

# Summary of findings

- The practice had recently started to offer NHS health checks to patients aged between 40 and 75 but these were offered on an ad hoc basis. Patients in a care home had an annual health check.
- Data showed patient outcomes were in line with local and national averages.
- Clinical audit cycles were carried out and there was evidence of improvements being made.

**Are services caring?**

**Requires improvement**

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Some patients told us they had been provided with a chaperone without requesting one, with one patient saying they found this embarrassing as they knew staff at the practice.
- Data from the national GP patient survey published in July 2016 showed patients rated the practice in line with others for several aspects of care.
- Most 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 easy to understand and accessible.

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

**Requires improvement**

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

- Patients could get information about how to complain in a format they could understand. However, although there was a complaints flowchart in place this was not followed. Complaints were not always investigated, a written response was not always provided for complaints, including written complaints, and patients were not told how they could escalate their complaint if they were unhappy with how it had been dealt with by the practice.
- Some patients told us appointments were difficult to access. However, we saw evidence on the day of our inspection that emergency appointments were available and routine appointments were available the following working day.
- There was no extended opening at the practice.
- There was no protocol for assessing the urgency of home visit requests when the request was made.

# Summary of findings

**Are services well-led?**

Inadequate

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

- The practice had a mission statement but staff were unaware of what this was.
- Staff did not receive regular performance reviews, and there was no record of some being carried out for over four years.
- Although the partners had a good understanding of their clinical performance they had no insight into the wider issues identified during the inspection.
- Some staff were unclear about who their line manager was.
- Two of the partners were not registered with the CQC, with one being a partner for two years.

# Summary of findings

## The six population groups and what we found

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

### Older people

Inadequate

The practice is rated as inadequate for the care of older people. The provider was rated as inadequate for providing safe, effective and well-led services, and requires improvement for providing caring and responsive services. The issues identified as inadequate affected all patients including this population group.

- The safety of care for older people was not a priority and there were limited attempts at measuring safe practice.
- Home visits were not managed in a way that identified those in urgent need of medical attention.
- The practice wrote to older patients in June 2016 to tell them who their named GP was.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line with local and national averages.
- Patients living in residential care or nursing homes had a care plan in place and were visited by the GP at least four times a year.

### People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The provider was rated as inadequate for providing safe, effective and well-led services, and requires improvement for providing caring and responsive services. The issues identified as inadequate affected all patients including this population group.

- Home visits were not managed in a way that identified those in urgent need of medical attention.
- Performance for diabetes related indicators was 91%. This was the better than the CCG average of 87% and the national average of 90%. Patients with a long term condition had a structured annual review.

### Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for providing safe, effective and well-led services, and requires improvement for providing caring and responsive services. The issues identified as inadequate affected all patients including this population group.

# Summary of findings

- Not all staff had been trained in safeguarding children and not all had an awareness of safeguarding.
- Young people under the age of 16 were unable to book an appointment without their parent or guardian being present.
- Immunisation rates for the standard childhood immunisations were in line with local and national averages.
- The practice's uptake for the cervical screening programme was 82%, which was the same as the CCG and national averages.

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

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The provider was rated as inadequate for providing safe, effective and well-led services, and requires improvement for providing caring and responsive services. The issues identified as inadequate affected all patients including this population group.

- Appointment times were limited, with no regular extended opening, making it difficult for working patients to access appointments.
- NHS health checks for patients aged 40 to 75 had only recently started, and were offered on an ad hoc basis.

**People whose circumstances may make them vulnerable**

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for providing safe, effective and well-led services, and requires improvement for providing caring and responsive services. The issues identified as inadequate affected all patients including this population group.

- Not all staff had been trained in safeguarding adults and not all staff had an understanding of safeguarding.
- The practice held a register of patients living in vulnerable circumstances.

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

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider was rated as inadequate for providing safe, effective and well-led services, and requires improvement for providing caring and responsive services. The issues identified as inadequate affected all patients including this population group.

# Summary of findings

- Counselling services were available in the area and these were usually by self-referral.
- Performance for mental health related indicators was 100%. This was better than the CCG average of 92% and the national average of 93%.
- The number of patients with dementia having an annual face to face health check was in line with local and national averages.
- Clinical staff had a good understanding of consent and the Mental Capacity Act 2005.

# Summary of findings

## What people who use the service say

The most recent national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. 317 survey forms were distributed and 107 were returned. This represented 1.4% of the practice's patient list.

- 71% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 73% and the national average of 73%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and the national average of 85%.
- 87% of patients described the overall experience of this GP practice as good compared to CCG average of 85% and the national average of 85%.
- 78% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the CCG average of 77% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards, and most were positive about the standard of care received. Patients said staff were friendly and GPs listened to their concerns. Some patients commented it was difficult to get through on the telephone and that appointments were sometimes difficult to make.

We spoke with 10 patients during the inspection, including two who were members of the patient participation group (PPG). Three patients told us it was difficult to access appointments but the other patients we spoke with told us they did not have difficulty with this. Other feedback was mixed. Some patients told us they were not given support when needed but others told us they were happy with GPs and staff and they felt listened to.

## Areas for improvement

**Action the service MUST take to improve**

- The provider must introduce effective governance procedures. These must include processes for reporting, recording, acting on and monitoring significant events, incidents and near misses, investigating and responding to complaints, ensuring all medical equipment is within its expiry date and assessing the performance of non-clinical aspects of the practice, making improvements where issues are identified.
- The provider must ensure all relevant training for staff is completed and training is monitored so it can be repeated at appropriate intervals.
- The provider must review chaperone procedures to avoid embarrassment to patients. In addition they must ensure access to appointments is available for patients under the age of 16 who have the appropriate level of competence and wish to attend without a parent or guardian.
- The provider must complete all recruitment checks are in place to ensure staff are of good character.
- The provider must assess the health and safety of patients and staff at the practice and take action where issues are found. This includes having fire safety assessments and checks in place.

**Action the service SHOULD take to improve**

- The provider should improve access to health checks for patients aged 40 to 75 and the over 75 age group who are not in care homes.

# Summary of findings

- The provider should have a system in place to improve their identification of carers and offer more formal support to carers.
- The provider should review their arrangements for home visits so patients in need of urgent medical attention are easily identified.
- The provider should provide up to date appraisals for staff.

# Springfield House

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and an expert by experience.

## Background to Springfield House

Springfield House is situated to the north west of Oldham town centre. It is located on a main road with street parking available. The practice is in purpose built single storey premises with a basement.

At the time of our inspection there were 7770 patients registered with the practice. The practice is overseen by NHS Oldham Clinical Commissioning Group (CCG). It delivers commissioned services under the General Medical Services (GMS) contract.

There are four GP partners, two male and two female. Two GP partners are not registered with the Care Quality Commission. There are two practice nurses and a healthcare assistant. The non-clinical team consists of a practice manager, a deputy practice manager, an office manager and reception and administrative staff.

The practice is open from 8am until 6.30pm Monday to Friday.

Pre-bookable appointments are available between the following hours:

Monday 8.30am until 5.50pm

Tuesday 8am until 4.40pm

Wednesday 8.30am until 4.50pm

Thursday 8am until 4.50pm

Friday 8am until 4.30pm

The age distribution of patients is in line with the national average, and the number of patients with a long term health condition is also similar to local and national averages. The practice area is in the third most deprived decile on the deprivation scale. Life expectancy for males in the area is 76 years (CCG average 76 and national average 79) and for females it is 81 years (CCG average 81, national average 83).

The practice is a training practice for trainee GPs.

The practice has opted out of providing out of hours services for its patients. This service is provided by a registered out of hours provider, Go To Doc Ltd.

## Why we carried out this inspection

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

A previous inspection had been carried out 18 March 2015 and as a result requirement notices had been issued to the practice. This inspection was also to check the required improvements had been made.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30 September 2016. During our visit we:

- Spoke with a range of staff including GPs, the practice nurse, healthcare assistant, practice manager and reception and administrative staff.
- Observed how patients were being spoken with by staff.
- Spoke with patients including members of the patient participation group.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed policies and procedures.
- Reviewed documents such as personnel records.

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

Our inspection of 18 March 2015 found several issues relating to the safe domain. Not all significant events were recorded and there was little evidence of learning from significant events. Staff had not received training in safeguarding adults. Disclosure and Barring Service (DBS) checks had not been carried out for non-clinical chaperones. Medicines were not kept securely and out of date medicines were found. Training had not been carried out in infection control for several years and infection control audits had not been carried out. Safety checks such as for portable electronic equipment and fire extinguishers had not been carried out. Sharps bins were not attached to walls and were within reach of patients. Equipment was found to be past its expiry date. Appropriate recruitment checks were not taking place.

During this inspection we found improvements were still required in this domain.

**Safe track record and learning**

The system for reporting and recording significant events was not effective.

- Clinical staff had a good understanding of significant events but did not always record them. However, non-clinical staff told us they were unaware of what should be reported and they told us they were not involved in significant events.
- The practice manager told us significant events were discussed at the monthly clinical meetings. Meeting minutes showed learning was shared between clinicians.
- We saw a prescription issued for a child had been recorded on their parent's records. The practice manager acknowledged that this should have been reported as a significant event, but no record had been made.
- During the inspection we were told there were currently no reviews of significant events, but due to a change in the GPs working at the practice a GP was taking responsibility for this and would complete an annual review of significant events in the future. Following the inspection the GPs told us there had been an analysis of all significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that when significant events had been correctly reported lessons were shared and action was taken to improve safety in the practice. For example, following a two week referral being missed the referral policy was amended and secretaries sent GPs a message when the referral had been made.

**Overview of safety systems and processes**

The practice did not have had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- The practice had a safeguarding folder containing various documents. This included an 84 page document, 'NHS England Greater Manchester Safeguarding in Primary Care: Children and adults at risk'. This document contained Care Quality Commission (CQC) guidance that stated a practice was likely to fulfil the requirements of CQC if they complied with guidance relating to Disclosure and Barring Service (DBS) checks, ensured staff were trained, and had a safeguarding adults and children policy. Although we saw information displayed containing local safeguarding contact numbers, and there was a document available to inform staff how to make a referral, there was no practice specific policy. Training records showed not all staff had received training in safeguarding adults and children.
- There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Although clinicians had a good understanding of safeguarding procedures one non-clinical staff member who had worked at the practice for several years did not have an understanding and there was no record of them being trained.
- 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 chaperone policy, dated July 2016, stated that if a clinical staff member was not available to chaperone

during an intimate examination the examination should be deferred. The practice manager told us this was incorrect and reception staff chaperoned. Two of the 10 patients we spoke with commented on the use of chaperones. One told us they had been told they had to have one present during an examination, and another said they were given a chaperone even though they did not ask for one. They told us they did not like this and felt embarrassed as they knew some of the staff.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. A GP was the infection control clinical lead. There was an infection control protocol in place. Not all staff, including some clinicians, had received infection control training, but handwashing training had been carried out. An infection control audit had taken place in August 2016. No action plan had been put in place following the audit, although few issues had been identified.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) medicine management team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions to allow nurses to administer medicines in line with legislation had been received by the practice from the CCG. During the inspection the practice manager told us these had not been formally adopted by the practice or signed by a GP or the nurse using them, which meant the nurses had not received formal authorisation to administer the medicines. The practice manager told us they asked the nurses to read them then kept an electronic copy of the original document. However, following the inspection the lead GP told us this was incorrect and signed copies of the patient group directions were kept by the practice nurse.
- We reviewed eight personnel files, including those of four staff members who had started work since our last inspection. We found that not all appropriate checks had been completed for these four staff members. For example, where a staff member had previously worked in health or social care, or with children or vulnerable adults, evidence of their conduct during the employment, and the reasons they had left, had not been sought. On two occasions the information provided in the staff member's CV differed from that in references that had been obtained. This had not been queried. There were no periodic checks to ensure clinicians had up to date registration with the appropriate professional body.

**Monitoring risks to patients**

Risks to patients were not well assessed or managed.

- Although staff told us checks were in place we found several out of date items including medical instruments five years past their expiry date.
- There was no health and safety risk assessment for the practice. In August 2016 the practice had employed a company to manage their health and safety. The practice manager told us they had carried out a risk assessment but they had not yet received any information about it. We saw areas within the practice where the safety of patients or staff could be compromised. For example there was a broken door closure in a consultation room so the door slammed and trip hazards were identified.
- Following the inspection the practice sent us a copy of the health and safety audit action plan completed by the external company, that had been sent to them after our inspection. This highlighted the areas of high, medium and low risk that had been identified. The company had given the practice an action plan showing action required in 69 areas. Seventeen of these actions were considered to be high risk. For example there was no health and safety policy, there was no risk assessment for slips, trips and falls and there was no evidence of any risk assessments for the Control of Substances Hazardous to Health (COSHH). In addition 39 actions were considered a medium risk and 13 actions low risk. The practice manager told us they had a meeting with the health and safety manager from the external company arranged for 21 November 2016 so they could go through the report and ensure they fully understood it and could take the appropriate action.
- We saw that the fire alarm was tested at monthly intervals. However, the records showed a test had been completed for October 2016, following the inspection

date, which raised doubts about the validity of the records. British Standards specifications state fire alarms should be tested once a week by the responsible person. The practice manager confirmed they did not complete checks of emergency lighting or emergency escape routes. No fire drills had been carried out and the practice manager told us they were hoping to start these. A fire risk assessment had been carried out by the practice manager in July 2016 but these issues had not been highlighted. We saw no evidence the practice manager had received fire safety training. The fire risk assessment had highlighted that easily combustible materials presenting a fire hazard were in the workplace, but although the practice manager had signed off the risk assessment document they had not completed the action plan that was included in the document. We saw that a basement room contained open shelving full of medical records. The room had a glass fronted door that was not a fire door.

- The practice did not have a Legionella risk assessment and no tests were carried out (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice manager told us the company they had recently employed said a risk assessment was not necessary.
- Portable electronic equipment had been tested to ensure it was safe and medical devices had been calibrated within the previous 12 months.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

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

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

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. However, the ambubag and mask, used to provide ventilation to patients who are not breathing or not breathing adequately, were perished and not functional. A first aid kit and accident book were available.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice manager told us all staff received basic life support training, with clinicians being trained annually and non-clinical staff every three years. We saw evidence that most staff had received training within these timescales. Emergency medicines were available in the treatment room.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

Our inspection of 18 March 2015 found staff training was not well managed.

During this inspection we found improvements were still required in this area.

**Effective needs assessment**

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Guidelines were discussed at clinical meetings. We saw evidence that Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were disseminated to clinicians by email and stored to provide guidance.

**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 showed the practice achieved 96% of the total number of points available. This was in line with the CCG and national average of 95%. Exception reporting was also in line with the CCG and national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed:

- Performance for diabetes related indicators was 91%. This was the better than the CCG average of 87% and the national average of 90%. Exception reporting was in line with the CCG and national averages.
- Performance for mental health related indicators was 100%. This was better than the CCG average of 92% and the national average of 93%. Exception reporting for all mental health related indicators was above the CCG and national averages.

There was evidence of quality improvement including clinical audit.

- There had been several clinical audits completed in the last two years, some of which were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, atrial fibrillation audits highlighted which patients required anticoagulation medicines. Atrial fibrillation is an irregular heartbeat that can lead to blood clots, stroke and heart failure. Anticoagulants are medicines that help prevent blood clots.

Some areas relating to medicines had not been identified. For example:

- GPs told us systems were in place to monitor the prescribing of high risk medicines. However no searches were carried out to ensure the perceived monitoring was taking place.
- No reviews were undertaken for patients prescribed new oral anticoagulants (NOACs). These doses should be varied depending on the age of the patient and their renal function.

**Effective staffing**

Evidence was not available to show staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. Training was not covered by the induction programme, which covered an introduction to the practice, and we saw an example of a staff member who had worked at the practice for over six months who had not been trained in safeguarding or fire safety. Staff told us there was a six month probation period when they started work and they had an informal discussion with their manager at that stage.

Inadequate

# Are services effective?

## (for example, treatment is effective)

- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. The nurses managed their own continuing professional development but this was not monitored by the practice. This included for example updated training for those reviewing patients with long-term conditions. There was little information kept relating to training completed by the GPs or nurses.
- Training for non-clinical staff was not well monitored. We saw the training records contained several gaps where staff had not received relevant training, for example in safeguarding, fire safety or infection control. The practice manager told us there was protected learning time for staff and staff told us if they completed on-line training at home they were given time off work in lieu of the training time.
- Some of the staff were unsure of who their line manager was, with one staff member who had worked at the practice for several years saying they had not been allocated a line manager but they had a lot of support from the management team.
- Appraisals for staff had not been carried out for over 12 months, and we saw the last recorded appraisal for some long standing staff had been carried out in March 2012. The practice manager acknowledged that they were behind with appraisals but thought one had been carried out since then. They thought they might be kept in a computer folder but they were unable to confirm this. Staff told us they felt well-supported at work.

**Coordinating patient care and information sharing**

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care 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. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. Meetings were scheduled for the year and sent to all relevant staff so staff from the multi-disciplinary team knew when they were taking place.

**Consent to care and treatment**

Although staff sought patients' consent to care and treatment in line with legislation and guidance, not all were aware of guidance relating to children and young people.

- Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, not all staff carried out assessments of capacity to consent in line with relevant guidance. For example, the practice manager told us young people under the age of 16 were not usually seen without a parent or guardian, and the parent or guardian would also need to be present at the point of making the appointment. They said there was no policy in place for the booking of appointments by patients under the age of 16 years. However, clinical staff were aware of the Gillick competence (Gillick competence is used in medical law to decide whether a child aged 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).
- 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. 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. Patients were signposted to the relevant service.
- The nurses offered weight management advice.

Inadequate

# Are services effective?

## (for example, treatment is effective)

- A drug and alcohol worker attended the practice each week and a nurse to help patients reduce the amount of some medicines also attended weekly.

The practice's uptake for the cervical screening programme was 82%, which was the same as the CCG and national average. Although a policy was not in place some staff told us they offered telephone reminders for patients who did not attend for their cervical screening test.

Childhood immunisation rates for the vaccinations given were usually above the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 100% and five year olds from 66% to 98%.

The practice had started in the previous three months to offer NHS health checks on an ad hoc basis to patients aged 40 to 75. They told us patients in care homes had an annual health check.

Requires improvement

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in the consulting rooms of some GPs, and some used adjacent side rooms to examine patients.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff told us they knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. They said this was rarely required as patients respected a notice asking them to stand back from the reception desk.

We received 34 patient Care Quality Commission comment cards and most 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.

We spoke with 10 patients, plus two members of the patient participation group (PPG). Their comments were mixed. Most told us that staff were friendly and approachable. One person said privacy was sometimes difficult at the reception desk as staff sometimes shouted.

Two of the 10 patients we spoke with commented about the arrangements made for chaperoning. One had been told they had to have a chaperone present during an examination. Another said they had been given a chaperone although they had not requested one. They said they did not like this and found it embarrassing as they knew some of the staff.

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 83% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 89% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

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

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

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

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 95% 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 the national average of 85%.

Requires improvement

# Are services caring?

The practice provided facilities to help patients be involved in decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language, although this was not promoted in the waiting area.

**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. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 71 patients as carers (under 1% of the practice list). There was information available in the waiting room about carers' groups in the area. The practice did not offer carers' health checks but said they offered all carers a flu vaccination.

Staff told us that if families had suffered bereavement GPs could choose to contact them if they had been closely involved in the patient's death. They gave leaflets to patients if they requested bereavement counselling and patients self-referred to that service.

Counselling was available in Oldham town centre and patients with mental health issues could self-refer to the Healthy Minds service, provided by the local NHS trust.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

The practice did not always review the needs of its local population and engage with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services.

- No regular extended opening times were offered.
- Appointments were usually for 10 minutes but some staff told us longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. However, there was no protocol for assessing the urgency of home visits, which were recorded in a book checked by GPs periodically.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities and translation services available. There was no hearing loop.
- One of the GPs spoke Polish and staff said Polish patients liked to register with the practice so they could see a GP without needing an interpreter. The practice told us another GP could also speak a second language.
- The practice had an electronic check in facility. However, during our inspection we saw that few patients used this resulting in long queues at the reception desk.

**Access to the service**

The practice was open between 8am and 6.30pm Monday to Friday. The lead GP told us following the inspection that appointments were available:

Monday 8.30am until 5.50pm

Tuesday 8am until 4.40pm

Wednesday 8.30am until 4.50pm

Thursday 8am until 4.50pm

Friday 8am until 4.30pm

During the inspection the practice manager had told us appointments finished earlier, and the website information does not match the information above. Extended opening hours were not usually offered. During the inspection the practice manager told us there was a duty GP on call until 6pm each day. Following the inspection the GPs told us the duty GP was on call until 6.30pm daily. If it was felt a patient needed to see a GP urgently the duty GP would arrange to see them. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Three of the patients we spoke with told us it was difficult to make an appointment, even in an emergency. However, we saw that appointments were available. On the day of our inspection we saw there was an emergency appointment available with the duty GP that afternoon. The next available routine appointment was the following working day. The practice manager told us they had not monitored the availability of on the day appointments for approximately three years. Appointments were available through the GP federation at a nearby practice until 8pm Monday to Friday and from 10am until 2pm on Saturday and Sunday.

Results from the national GP patient survey published in July 2016 showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 86% of patients were satisfied with the practice's opening hours compared to the national CCG average of 78% and the average of 76%.
- 71% of patients said they could get through easily to the practice by phone compared to the CCG average of 73% and the national average of 73%.

The practice did not have effective systems in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.

We saw that when a patient requested a home visit it was written in a visits book and not recorded on the computer system. GPs told us they checked the book between 10am and 12 noon, and from 12 noon the duty GP triaged requests in the book. Staff told us that if they felt a visit was urgent they would contact a GP. However, a GP told us there was no protocol in place for staff to follow to assess the urgency of a visit request.

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

**Listening and learning from concerns and complaints**

The practice did not have an effective system in place for handling complaints and concerns. There was some confusion about who the lead GP for complaints was; one GP told us it was them but records and other staff named a different GP. There were two complaints procedures in place, one dated January 2016 and another dated February 2016. These were slightly different but stated all written and verbal complaints would be recorded and a written response would be given. There was a flow chart in place to give guidance about how to deal with complaints. However, this was not being followed.

We saw that not all complaints were investigated appropriately. One person had made a verbal complaint giving full details about a breach of confidentiality in the practice. They requested an apology. A telephone call was made to the complainant telling them they could attend a meeting but they declined this. They were told they could make a formal complaint in writing. This was not made and no further action was taken to investigate the complaint. Another written complaint was annotated on the bottom "Spoken to (the patient) and apologised". No written response had been given.

None of the complaints responses we saw gave information to the patient about how they could escalate their complaint. The complaints procedure dated February 2016 stated that patients could contact NHS England if they were not satisfied with how their complaint had been handled. The correct body to contact is the Parliamentary and Health Service Ombudsman (PHSO) and this information was included in the flow chart that was available. Clinical complaints were discussed in clinical meetings. Non-clinical complaints were only discussed with staff if they were personally involved so there was no shared learning.

# Are services well-led?

Inadequate

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

## Our findings

Our inspection of 18 March 2015 found that policies were out of date or not fit for purpose. Staff were unaware of the statement of purpose and their responsibilities in relation to it. Meetings were informal, lacked structure and were not well documented. There was a lack of management responsibility in some areas such as medicines management and safety alerts.

During this inspection we found that although improvements had been made in most of these areas other areas of concern were highlighted.

**Vision and strategy**

Although the GPs had a clear vision to deliver high quality care and promote good outcomes for patients this was not evident in other staff groups.

- The practice had a mission statement - "The Practice is here to give our patients high quality care. Whilst you are visiting our premises you have the right to expect courtesy and consideration from our staff, our patients and visitors". Four of the staff we spoke with told us they knew one had been put in place recently but they did not know what it was.
- GPs told us they felt the clinical quality of the practice had improved since the last inspection in March 2015.
- The practice manager wrote to the Care Quality Commission (CQC) on 2 August 2016. In this letter they stated that all the requirements of the previous inspection had been addressed. As part of the presentation given to CQC at the beginning of this inspection they stated they had been upset by the previous inspection report and thought the required improvements had been made. The breaches of regulation found during this inspection show that adequate monitoring of the service to ensure high quality care and positive outcomes for patients had not taken place.

**Governance arrangements**

The practice did not have an adequate overarching governance framework to support the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However, some staff were unaware of who their line manager was.
- The partners and practice manager did not have an understanding of the performance of the practice outside the clinical targets.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not in place. For example, the practice manager told us since the previous inspection systems were in place to dispose of outdated equipment. However, equipment past its expiry date was found in a clinical room during this inspection.
- Two partners at the practice were not registered as such with the CQC. One had been a partner for over a year and the other had been a partner for two years.
- Some areas of improvement had been made since the previous inspection. For example there was a programme of continuous clinical and internal audit used to monitor quality and to make improvements, and policies had been updated.

**Leadership and culture**

Although staff told us they felt supported by management there was confusion about the management structure. Some staff were unaware of who their line manager was as they said they went to different managers with different issues. Staff told us the partners were approachable and always took the time to listen to all members of staff.

- Practice meetings were held each month but not all staff attended these. Clinical meetings were also held at least once a month. Administrative staff attended meetings less frequently, approximately twice a year. However, staff told us they received regular updates by email in-between these meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues with managers.
- Partners encouraged members of staff to identify opportunities for them to improve. We saw that one of the reception team had trained to be a healthcare assistant, and they had recently progressed to train as an assistant practitioner.

# Are services well-led?

Inadequate

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

- Staff appraisals had not been carried out for at least a year. We saw examples of no recorded staff appraisals for over four years. The practice manager told us the assistant manager would start appraisals in March 2017. However following the inspection the GPs told us they would commence in January 2017.

Although there had been no serious harm caused to a patient due to a clinician failing to share information, the practice did not always give people affected by incidents reasonable support, truthful information and a verbal and written apology. Non-clinical staff were unsure of what incidents should be reported, and we saw evidence that not all incidents were correctly recorded as significant events so they could be investigated appropriately. In addition, not all complaints, including complaints made against clinicians, were investigated or appropriately responded to. Systems to ensure compliance with the requirements of the duty of candour were therefore not strong. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

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

The practice had a patient participation group (PPG) that met approximately every three months. We met with two members of the group who spoke very positively about the practice. They said they hoped to encourage more patients to join the PPG as usually only three to four patients attended meetings and the group was not representative of the patient population. The PPG members told us they were shocked and surprised at the last inspection report but they had not been involved in discussions to make improvements following this being published. They said they had made some suggestions. They suggested participating in the Lions 'message in a bottle' scheme. This is a way to keep essential personal and medical details where they could be found in an emergency, in a small tub. This had been taken on by the practice and patients could collect a tub from the reception. They told us they had also suggested photographs of doctors were displayed in the waiting room. Following the inspection the practice told us that although this had been considered it would not be implemented due to staff not wanted to have their photographs displayed.

The practice manager told us an in-house satisfaction survey had been completed in May 2016. They said the response had been poor. The results had not been shared with patients. There was no suggestions box available at the practice.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>**The registered person did not support the autonomy or independence of all patients. Not all patients were treated with dignity and respect. This included arrangements for chaperones and patients under the age of 16 being able to access appointments without a parent.**<br>**This was in breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**The registered person did not follow processes to ensure all staff were of good character. Information specified in Schedule 3 was not available for all staff.**<br>**This was in breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The registered person did not assess risks to the health and safety of service users or mitigate risks. They did not ensure the premises or equipment were safe. Training, including mandatory training such as fire safety and safeguarding, had not been provided for all staff.<br><br>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 | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The registered person did not have systems and processes in place to ensure compliance with the regulations. There was no system in place to monitor, assess and improve the quality of the service. The registered person did not ensure all identified risks were acted on. Complaints were not always appropriately investigated or responded to. Accurate records were not always kept by the practice in relation to staffing. These included records relating to training, recruitment records, and ongoing professional registration.<br><br>This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |