Dr Mark Stevens

Quality Report

Mapperley Park Medical Centre
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Date of inspection visit: 13 and 14 March 2015
Date of publication: 11/06/2015

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?	Good
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 Mark Stevens (Mapperley Park Medical Centre) on 13 and 14 April 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective and responsive services, and being well led. It was good for providing caring services. The concerns which led to these ratings apply to all population groups using the practice.

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

- Patients were at risk of harm because systems and processes were not sufficient or robust enough to keep them safe. For example, appropriate recruitment checks on staff had not been undertaken prior to their employment, and actions identified to address concerns with infection control practice had not been completed.
- Although staff understood their responsibilities to raise concerns, and report incidents and near misses, safety was not sufficiently prioritised and there were inadequate systems in place to record, monitor and manage risks.
- There were unsuitable arrangements in place to ensure there were sufficient staffing levels and an appropriate skill mix to deliver services and support patients.
- Staff had not received essential training appropriate to their roles and any further training needs had not been identified and planned.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example, assessment of their care and treatment needs and timely reviews of repeat medicines.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

Summary of findings

- Same day appointments were usually available on the day they were requested. However patients said that they sometimes had to wait up to two weeks for non-urgent appointments.
- The practice had insufficient leadership capacity and very limited formal governance arrangements to enable assessment and monitoring of the service and the identification and management of risks.

The areas where the provider must make improvements are:

- Ensure appropriate action is taken to address identified concerns with infection prevention and control practices to ensure patient and staff safety.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure staff are competent and skilled to perform their roles and responsibilities through the delivery of appropriate training, professional development, and regular supervision.
- Ensure there are formal governance arrangements in place and staff are aware how these operate. This includes effective systems for assessing and monitoring risks, and the overall quality of service provision.
- Ensure patient records and records relating to the management of regulated activities are kept securely and fit for purpose. This includes staff having appropriate policies and guidance to carry out their roles.
- Ensure a statement of purpose is in place and that all staff understands the practice's vision and their responsibilities in fulfilling this.
- Ensure the regulated activities are managed by an individual with the appropriate knowledge of applicable legislation including the Health and Social Care Act 20087 (Regulated activities) Regulations 2014 and relevant best practice and guidance.
- Ensure on-line facilities are available for repeat prescriptions and on-line appointments.

The areas where the provider should make improvement are:

- Review the processes for making appointments.
- Review arrangements for involving the practice team in decisions about the delivery of services

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.

Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe. For example, areas of concern included recruitment, infection control, health and safety risks associated with the environment, staffing, management of unforeseen circumstances and dealing with emergencies.

The absence of effective systems meant there were risks to patients, staff and visitors which had not been identified or acted upon in order to keep them safe. Staff were clear about reporting incidents, near misses and concerns. However, this was not recorded and lessons learned were not communicated and so safety was not improved.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

Are services effective?

Inadequate

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

Although staff referred to guidance from National Institute for Health and Care Excellence (NICE); patient's needs were not adequately assessed, and care was not planned and delivered in line with best practice.

Staff inductions and training was not appropriate to their roles and further training needs had not been identified and planned. We saw limited evidence to evidence that audit was driving improvements in performance and patient outcomes.

The most recent available data from 01 April 2013 to 31 March 2014 showed patient outcomes were at average or slightly above for the locality. There was minimal evidence of engagement with other providers of health and social care to ensure patients received co-ordinated and effective care or to benchmark the effectiveness of service provision.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Feedback from patients about their care and treatment was consistently and strongly positive. We also saw that staff treated patients with kindness and respect, and maintained confidentiality on most occasions.

Staff supported patients to cope emotionally with their health and condition. People were supported to manage their own health and care and to maintain their independence, where possible.

Are services responsive to people's needs?

Requires improvement

The practice is rated as inadequate for providing responsive services.

Most of the patients found it easy to make an appointment with the GP and there was continuity of care, with appointments available the same day. Patients told us that the practice's open system meant long waiting times of up to an hour and a half to be seen by the GP and this was a preferred compromise as they were seen the same day.

Although the practice had reviewed the needs of some its local population, it had not put in place a plan to secure improvements for all of the areas identified. This included patient access to a practice nurse and online services for working age people.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was not readily available in the practice and patient feedback showed they were not aware on how to make complaint should they need to.

We could not be assured that the systems to identify, respond to and learn from patient feedback were adequate and effective in driving improvements in services.

Are services well-led?

Inadequate

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

The practice did not have a clear vision and business plan setting out the aims and objectives of the practice and a strategy to achieve this. Staff held strong values in respect of providing a caring and person centred service. They understood how their roles contributed to achieving these values but were not aware of the overall practice vision or strategy.

Summary of findings

We found there was insufficient leadership capacity to assess and monitor the care and treatment provided. This impacted significantly on the delivery of an effective service and the provider lacked insight into the risks the absence of such leadership presented to patients. The provider had not been able to make and sustain improvements since our last inspection on 10 November 2014.

Although a clinical audit programme was in place this was not robust, effective and the information gathered was not sufficiently detailed to identify and drive improvements in effective care and treatment.

Most of the staff we spoke with felt supported by management. However, there were high levels of work overload and staff had not received regular performance reviews. The practice had a number of policies and procedures to govern activity, and most of these were overdue a review. This did not ensure that staff had up to date guidance to deliver safe and effective care.

The practice had a patient participation group (PPG) but regular meetings were not held to actively seek feedback from patients to help make improvements to the service.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. However, the practice did not have adequate systems in place to monitor and improve quality and identify risk.

People with long term conditions

Inadequate

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

The GP had the lead role in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.

However, not all patients with long term conditions had a personalised care plan or structured annual review to check that their health and care needs were being met and that the care and treatment being provided to them was appropriate and in line with best practice guidelines to maximise their health and wellbeing.

Families, children and young people

Inadequate

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

The most recent available data from 01 April 2013 to 31 March 2014 indicated immunisation rates were relatively high for all standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and some were not aware of how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

Working age people (including those recently retired and students)

Inadequate 

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

The data on the practice demographic indicated that the majority of practice patients were of working age, students and the recently retired but the services available were not targeted to meet the needs of this group.

Although there was an open access appointment system, there were no early opening hours for working age people and patients could not book appointments or order repeat prescriptions online. Patients were able to book non-urgent after two week period on average.

The practice could not produce data when requested to enable us to assess the current uptake for some health checks and health screening programmes.

People whose circumstances may make them vulnerable

Inadequate 

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

The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability and 71% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients had access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and some were not aware of how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate 

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

The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health but not always those with dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.	

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received nine completed comment cards and all were very positive about the care and treatment provided. Patients felt staff had a caring nature and treated them with respect and dignity. We also reviewed 56 completed NHS family and friends' test reviews; 54 patients stated they would recommend the practice.

We spoke with eleven patients who used the service including three members of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. All the patients we spoke with told us they valued the personal care and support they received from the practice. They expressed a high level of satisfaction about the way the services were provided.

Patients told us the GP and staff treated them as individuals, and showed genuine interest and concern for their health and wellbeing. Three patients gave examples of where the GP had gone the extra mile in providing care to them and / or their relatives. Feedback from patients and one health professional was continually positive in respect of the GP listening to patient care needs, involving them in decisions about their treatment and not feeling rushed during consultations.

This feedback was aligned with the national GP patient survey results from January 2015 which included feedback from 97 patients. For example, 92% of respondents described their overall experience of this surgery as good, 96% said the GP they saw or spoke to was good at treating them with care and concern and 81% described their experience of making an appointment as good.

Most patients told us they were happy with the appointment system as it ensured they were seen the same day if they contacted the practice by 11:15am. They acknowledged that a long waiting time was worth their while in respect of the service they eventually received.

However, some patients felt improvements were required to minimise this wait and increase the availability of appointments to accommodate working age patients in particular. Suggestions made included having two GPs providing services. Some of the patients also told us they were not fully aware of the health screening services provided and the process of making a complaint.

Patients told us the premises were clean, and that the facilities were accessible and appropriate for their needs.

Areas for improvement

Action the service MUST take to improve

- Patients were at risk of harm because systems and processes were not sufficient or robust enough to keep them safe. For example, appropriate recruitment checks on staff had not been undertaken prior to their employment, and actions identified to address concerns with infection control practice had not been completed.
- Although staff understood their responsibilities to raise concerns, and report incidents and near misses, safety was not sufficiently prioritised and there were inadequate systems in place to record, monitor and manage risks.
- There were unsuitable arrangements in place to ensure there were sufficient staffing levels and an appropriate skill mix to deliver services and support patients.
- Staff had not received essential training appropriate to their roles and any further training needs had not been identified and planned.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example, assessment of their care and treatment needs and timely reviews of repeat medicines.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Same day appointments were usually available on the day they were requested. However patients said that they sometimes had to wait up to two weeks for non-urgent appointments.
- The practice had insufficient leadership capacity and very limited formal governance arrangements to enable assessment and monitoring of the service and the identification and management of risks.

Action the service SHOULD take to improve

- Review the processes for making appointments.
- Review arrangements for involving the practice team in decisions about the delivery of services.

Dr Mark Stevens

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 second CQC inspector, a GP, a practice nurse and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr Mark Stevens

Dr Mark Stevens is a single handed GP providing primary medical services to approximately 2 320 patients in the Mapperley park and St Anns area.

The practice is located at Mapperley Park Medical Centre, Malvern House, 41 Mapperley Park Road, Nottingham, NG3 5AQ. It is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostic and screening procedures; maternity and midwifery services; and treatment of disease, disorder or injury.

The GP is supported by a female locum nurse who works on Tuesdays and Wednesdays, a full time practice manager and two part-time reception staff. Dr Mark Stevens is a teaching practice for undergraduate medical students. There were no students on placement at the time of our inspection.

The practice holds a General Medical Services (GMS) contract for the delivery of general medical services. This is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice provides a range of services including well baby clinics and immunisations, antenatal care, family planning, travel vaccinations and health screening checks.

The practice operates weekdays between the hours of 8am and 6.30pm; and has opted out of providing out-of-hours care to their own patients. Out-of-hours care is provided by Nottingham Emergency Medical Service (NEMS) through the 111 number.

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.

At our previous inspection on 14 August 2014, we found care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014. We also inspected this service as we had received information of concern which indicated that patients may be at risk.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data (QOF), this relates to the most recent information available to the CQC at that time. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions.

Detailed findings

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS England and Nottingham City clinical commissioning group (CCG). A CCG is a group of general practices that work together to plan and design local health services in England. They do this by commissioning or buying health and care services.

We carried out an announced visit on 13 and 14 April 2015. During our visit we spoke with a range of staff including the GP, practice manager, two reception staff and a locum practice nurse. We also spoke with eleven patients including three members of the patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

We observed interactions between staff and patients, and how people were being cared. We reviewed patient records to corroborate our findings during the inspection. We received nine completed patient comments cards. Following our inspection we spoke with two health professionals from the health visiting and midwifery services.

Inadequate

Are services safe?

Our findings

Safe track record

Overall, we could not be assured of the practice's safe track given its history of non-compliance with the regulations from three previous inspections; and concerns identified at this inspection. The areas of concerns included not have suitable arrangements for: identifying, recording and managing risks; as well as assessing and monitoring the quality of service provision.

The practice GP told us they received national patient safety alerts and reviewed if they were relevant to the practice. The GP gave an example of an alert received from the Medicines and Healthcare Regulatory Authority (MHRA) and described the implications for their prescribing practice.

The alert related to domperidone (used to treat nausea and vomiting) being available as a prescription only medicine from 04 September 2014 due to increased risk of serious side effects. A copy of the alert was kept in the locum GP folder for reference and the GP was able to explain the action taken to address this.

However, the review of safety alerts was done on an individual basis and not routinely disseminated to all clinical staff; and written records were not available to evidence action taken in response to the alert.

The new practice manager told us there were no recorded safety records or incident reports since our previous CQC inspection on 10 November 2014. They showed us a book they had introduced for staff to record any accidents or incidents. The staff we spoke with were aware of their responsibilities to raise concerns with the GP or practice manager, and knew how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a policy in place for reporting, recording and monitoring significant events. However, some staff were not aware of this policy and / or did not implement it in practice. For example, we were informed of an incident where the fridge temperature daily record had fallen to 1.5 degrees, below the recommended temperature for storing vaccinations. If these medicines are not stored within the manufacturer's recommended temperatures they may become ineffective.

The practice staff had taken action to ensure the medicines were safe for administration but this significant event had not been documented and discussed with all staff to promote shared learning. This was not in line with the practice's significant event policy.

Staff told us of a significant event involving a patient who had been verbally aggressive. They told us the event was reported to the GP who dealt with it satisfactorily and it was discussed with the staff team. However, there were no records to reflect this event had been documented and the learning that had taken place to minimise further risks; in line with the provider's violence and aggression policy.

The GP told us that significant events were a standing item on the staff meetings agenda, but no recent meetings had been held due to low staffing levels. Therefore this limited the opportunities for disseminating and sharing learning with all staff after a significant had been identified.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice GP was the lead for safeguarding vulnerable adults and children. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern.

Staff told us they had received safeguarding training and could demonstrate they understood how to identify signs and types of abuse, and how to raise a concern with the lead. However not all staff were aware how to contact the relevant agencies in working hours and out of normal hours. Contact details were not easily accessible.

The practice policies in respect of safeguarding of vulnerable adults, child protection and whistleblowing were overdue for review to ensure they provided staff with up to date guidance.

Training records we looked at showed one staff member had not received relevant role specific training on safeguarding. This was because they were new in post and still undertaking their induction which included safeguarding awareness. Staff we spoke with were aware of their responsibilities to share information and properly record documentation of safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to

make staff aware of any relevant issues when patients attended appointments. For example children at risk of abuse or living in environments of domestic violence. Using a search on the patient electronic case management system, the GP was able to demonstrate the use of appropriate codes to ensure risks to children and young people were clearly flagged and reviewed.

The GP was aware of which patients were considered to be vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the child and adolescent mental health services (CAMHS) and providing reports to the multi-agency risk assessment conference (MARAC).

There was a chaperone notice visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

Staff told us the reception staff would act as a chaperone if nursing staff were not available. However, staff we spoke with were unable to demonstrate that they understood their responsibilities when acting as chaperones and neither criminal record checks nor risk assessments had been completed for staff expected to undertake chaperoning duties.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

Processes were in place to check medicines were within their expiry date and suitable for use. Most of the medicines we checked were within their expiry dates. Expired medicines were highlighted to staff to ensure they were disposed of in line with waste regulations.

Data reviewed showed the practice's performance in respect of prescribing was broadly better than the national average. The GP told us this was an area they regularly monitored and acted upon. For example, they told us they reviewed patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

Our review of 19 patient records showed incomplete or no medication review had taken place for four patients. This was in conflict with assurances given to us by the GP and did not provide evidence to demonstrate there was a regular review of patients' medicines and that appropriate action was taken if issues were identified as stated.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. A blank prescription form was found in the printer tray of the nurse's room and this was brought to the GP's attention. The tray and desk drawers were not locked, however the nurse's room was lockable. We saw that the prescription forms were secured in a safe manner thereafter.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be reasonably clean and tidy; although we noted shelves in treatment rooms were dusty and the reception area carpet was worn, frayed and stained. We saw cleaning schedules were in place and cleaning records were kept for the preceding seven months.

The practice GP was the lead for infection control and an infection control audit had been completed by Nottingham CityCare. An action plan dated 01 December 2014 had been agreed; and there was some evidence of action points having been completed.

Identified areas for improvement included: having a documented contingency plan in place should the vaccine fridge fail and the need for documented evidence of infection control training which incorporated effective hand washing every two years. We found the administrative staff had not received this training even though two of them had been in post for four and six months. There were no confirmed dates for training and discussions with staff showed this had not been covered during induction.

Not all of the areas for improvement identified in the action plan had been addressed. For example, the need to have

appropriate infection control policies had been identified as a priority area. We found the infection control policies lacked detail and would not enable staff to adequately protect patients and themselves from risk and spread of infection. The practice manager told us they were waiting for sample policies to adapt to the practice's working environment. Records to confirm staff's immunity to Hepatitis B (a blood borne virus) were not available when requested.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. The practice had a policy explaining what sharps were and a brief risk assessment for dealing with needle stick injuries. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The practice could not provide records when requested to confirm they were carrying out of regular checks to reduce the risk of infection to staff and patients. The GP was of the view that the practice was exempt on the basis of the type of building but there was no evidence of a recorded risk assessment to confirm this was not necessary.

We observed that pedal bins in the disabled toilet were not working and the waste bin in the treatment room was full and had not been emptied in the nurse's absence.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The practice nurse told us the practice would benefit from purchasing a modern spirometer and this had been shared with the GP. The practice manager told us all equipment was tested and maintained regularly. We saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw the last test was completed in February 2015. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, fridge thermometer and defibrillator.

We noted that the electrocardiogram (ECG) used to record electrical activity of a patient's heart had not been PAT tested and staff reported it did not work sometimes. We identified this may have been caused by not having a schedule of testing in place for reference. For example, staff told us PAT testing would have been completed on equipment that was made available / visible to the electrician on the day of the inspection. This system did not ensure that all equipment was properly tested for safety and effectiveness.

Staffing and recruitment

We looked at four staff records and all these demonstrated that appropriate recruitment checks had not been undertaken prior to employment. For example: the four staff files did not contain information to evidence that staff were physically and mentally fit for work and three staff files did not contain proof of identification and a photograph.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy stated, 'offers are made subject to taking at least two independent references," and "they (staff) are CRB checked.' We found two files did not contain references from previous employers and the remaining two contained only a single reference each.

No criminal record checks had been completed by the provider for all staff including checks with recruitment agencies for the locum clinical staff to ensure they were suitable to work with patients. The evidence demonstrated the practice staff did not follow their own policies.

The staff file for the locum GP did not contain evidence of their registration with the General Medical Council and confirmation that suitable checks that had been completed to ensure they were allowed to work by that body and they were on the performers list for NHS England.

People working at the practice told us they did not have enough staff to maintain the smooth running of the practice. Staff told us they regularly worked additional shifts and carried out additional duties to cover for the shortfall in staff numbers. The administrative team comprised of the practice manager and two reception staff of whom one had been in employed a week before our inspection.

Inadequate

Are services safe?

Low staff numbers and the impact on staff and patient care had been identified at our previous inspections of this service. The provider had submitted action plans detailing recruitment of additional staff but improvements made had not been sustained.

The GP explained that some of the staff turnover was due to poor performance. However risks associated with staffing changes (both planned and unplanned) had not been routinely assessed to ensure that mitigating actions were put in place in a timely manner to manage this and to ensure the continuity of care and the service.

Monitoring safety and responding to risk

We were shown a risk log developed by the GP, which addressed a range of potential issues, including lifting heavy weights, needle stick injuries and threat of violence in the work place. However, the practice did not have robust systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice.

The provider was unable to provide evidence to demonstrate that health and safety, lone worker risk assessments, annual and monthly checks of the building and the environment were undertaken. The practice had a health and safety policy and this was overdue for review. Health and safety information was not displayed for staff to see and staff were not aware of who the health and safety representative for the practice was.

Staff discussions showed some administrative staff were not able to identify and respond to changing risks to patients, including deteriorating health and well-being or medical emergencies. Staff were not provided with recorded guidance for triaging calls.

The GP gave us examples of referrals made for patients whose health deteriorated suddenly including supporting patients to access emergency care and treatment. We however noted that the practice had a no home visit policy for children and expected parents of sick children to bring them into the surgery or attend the walk in centre.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. For example, emergency equipment was available within the practice including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

All staff knew the location of this equipment and records confirmed that it was checked regularly. However, the administrative staff had not received basic life support training and this did not ensure that all staff were able to take action to deal with medical emergencies.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

The document also contained relevant contact details for staff to refer to. For example, contact details of a buddy practice should the building become uninhabitable. We saw that the plan was due for review in 2014 but this had not occurred.

The practice could not provide records when requested to evidence that a fire risk assessment specific to the building had been carried out. We saw that fire safety checks had been carried out by an external provider in April 2015.

On the first day of our inspection we asked practice staff to confirm which doors were used as fire exits. We identified a number of concerns in respect of fire safety and we referred these to the fire and rescue service for assessment. Staff we spoke with told us they had not received fire safety training nor practised fire drills.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

At our inspection on 14 August 2014, we were concerned about the care and welfare of patients who used the service. We asked the provider to send us an action plan outlining how they would make improvements. The provider's action plan stated improvements would be made by 19 October 2014 and would include: operating an effective recall system to ensure patients' health needs and medicines were regularly reviewed, and that incoming mail would be responded to in a timely way. In spite of this action plan and the provider's assurances, we found at this inspection that improvements had not been sustained.

The GP and nursing staff we spoke with could outline the rationale for their approaches to treatment. They referred to current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

However, out of the 19 patient records we reviewed, five records did not evidence that an adequate assessment of the patient's condition had been based upon their medical history, clinical signs and where necessary, appropriate examination. Three out of the five patient records did not provide evidence of a working diagnosis, and one of the three records showed no appropriate investigations / treatment had been provided.

There was no recorded information for two patients who had attended a consultation therefore we could not establish what care, treatment or medical advice they had received. We also found repeat prescriptions had not been reviewed when altering or adding medications in four patient records we reviewed. This showed that staff did not always complete thorough assessments of patients' needs in line with NICE guidelines, and / or review medicines when appropriate.

The GP was not making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. There was no recorded evidence to demonstrate regular reviews of elective and urgent referrals were undertaken, and that improvements to practice were shared with all clinical staff.

The GP had participated in CCG led Quality Practice Initiative meetings every year that they ran, concluding in 2014. However, at the time of our inspection the GP had limited participation in external peer review. This was due to concerns in respect of the practice's ability to deliver specific services under the Any Qualified Provider initiative. This initiative allows patients referred, usually by their GP, for a particular service to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations.

The benchmarking data we looked at showed the practice had outcomes that were comparable to other services in the area. Benchmarking is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

We found the practice's performance for 2013/14 antibiotic prescribing was above national average and national data showed the practice was above national average for emergency admission referral. The GP was aware of the prescribing performance and had reviewed this; but not the admission rates.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice did not have clearly defined roles in monitoring and improving outcomes for patients. Most of the monitoring was being undertaken by the practice manager, practice nurse and GP.

The practice showed us two clinical audits that had been undertaken in the past 36 months. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit.

The audit reviewed cancer cases between 11 March 2012 and 19 January 2013 to assess the time from presentation with signs and symptoms which may be indicative of cancer to referral, and time from referral to diagnosis. It also assessed whether patients were referred under the two week wait system. A second clinical audit was completed one year later which demonstrated appropriate follow-ups and investigations had been undertaken. The GP maintained a record showing how they had evaluated the service and documented the success of any changes.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the Quality Outcomes Framework and performance against some national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice met all the minimum standards for the 2013/14 QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease) for example. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended safeguarding vulnerable adults training. However, we could not find evidence that staff had received training in medical emergencies, information governance and health and safety which were relevant to staff's role.

We also had concerns regarding the skill mix of clinical staff given the practice nurse only worked two days a week and the practice had not formally audited the demand for nursing services to ensure it was sufficient to meet patients' care needs.

The GP was up to date with their yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

None of the six staff employed had received an annual appraisal as no one had been at the practice for more than year. The provider could not when requested provide us with any evidence to show there had been any assessment of the performance of any of these new staff during the year to ensure they were skilled and competent to undertake their role. The practice manager and staff told us supervision was not documented and this had been done informally.

The practice nurse worked as a locum. They informed us their main roles involved management of long term conditions, wound dressings, blood tests, health checks, travel vaccinations and childhood immunisations. The nurse told us she had been asked to run diabetes clinics but was aware her skills were not as strong in this area. She therefore arranged for a specialist diabetes nurse from the CCG to run the clinic.

Staff files reviewed showed poor performance had not been identified therefore appropriate action had not been taken to manage this. For example, we found documented evidence of concerns raised by another provider on 05 March 2015 about the clinical competence of one of the GP locums in their staff file. These included not undertaking home visits and telephone consultations. When we asked the GP what action had been taken in response to this feedback they told us they were not aware of these concerns.

Due to these concerns we reviewed a sample of six patients the locum had seen. We found for two patients, consultation notes had not been recorded and where information had been recorded this had not always been clear and contemporaneous. Two of the patient notes did not evidence that an adequate assessment based on history, clinical signs and appropriate examination had been taken. This presented a risk to patients receiving effective care and treatment.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

However, we found letters received from hospitals or out of hours services were not routinely reviewed by the GP on the day of receipt or before they were scanned. This did not ensure that actions required were implemented in a timely way. The GP told us that non-clinical staff currently read code information and concerns were raised by the CCG regarding the competence of administrative staff to undertake this role. We found none of the new staff had

Inadequate

Are services effective?

(for example, treatment is effective)

received formal training and the practice had not implemented its action plan to mitigate this risk. This included the GP auditing the summaries of patient records by undertaking spot check audits.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. The practice undertook some checks of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The GP had agreed to implement a follow-up of patients who did not attend their inpatient appointments from October 2014 in response to concerns raised by the CCG. We found limited records to evidence this was regularly being undertaken.

The practice held multidisciplinary team meetings monthly to discuss the needs of patients who may be at risk of hospital admission. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Information sharing

We identified concerns with record keeping and patient records at our previous inspection on 14 August 2014. We set a compliance action requiring the provider to make improvements.

During this inspection we found patient records in an unlocked drawer in the treatment room. These notes contained personal information including contact details and records of home visits. As a result of this concern, we checked the respective patient records and found nine contained incomplete information or unrecorded data to evidence the care and treatment patients had received. The practice did not undertake regular audits to assess the completeness of patient records.

The practice did not have an effective system to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. This system is used to scan paper communications, such as those from hospital, to be saved in the system for future reference.

Staff told us they were trained on the system, however they commented that the system was not easy to use and on occasions did not allow the practice nurse to see key essential information before a patient consultation. The midwife also commented that the use of different clinical systems meant they were not always able to access the same information as the GP about the patient.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were in place for making referrals, and this included the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Consent to care and treatment

We found non clinical staff had some awareness of the principles of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. However, they had no received training to ensure they fully understood their duties in fulfilling it.

All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, we saw that seven patients with learning disabilities and five with dementia had all received a health check and a care plan was in place.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The lead GP demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Inadequate

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected. A review of patient records showed health concerns were not always followed up in a timely way. For example, we found further investigations had not been arranged when a carer had raised concerns that their relative may have dementia in one patient record we reviewed. When interviewed, the GP told us they had spoken to the carer but not recorded the conversation in the patient record; we could therefore not verify this happened.

The GP told us the practice offered NHS Health Checks to all its patients aged 40 to 75 years. However, the staff could not provide us with data to show the percentage of patients in this age group who took up the offer of the health check and performance for national chlamydia, mammography and bowel cancer screening for the practice.

The practice had identified patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and seven out of seven were offered an annual physical health check. Practice records showed five had received a check up in the last 12 months.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. The GP used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. There was a policy to offer telephone reminders for patients who did not attend for cervical screening smears and the practice audited patients who did not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013/14 QOF data showed the practice's performance for immunisations was above average for the CCG, with the exception of immunisations for five year olds. This may be due to the statistically small patient group size of 4.3%.

The practice offered health promotion and health prevention advice to help patients with mental health problems. For example, the 2013/14 QOF data showed 75% of patients diagnosed with dementia had received a face-to-face review in the preceding 12 months.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey results, NHS Choices website and comment cards completed by patients as part of the family and friends test. The evidence from all these sources showed patients were satisfied with how they were treated, and this was with compassion, dignity and respect.

The national patient survey results showed the practice was well above the local average for its satisfaction scores on consultations with doctors and nurses. For example, 97% of the practice respondents said the GP was good at listening to them, 91% said the last nurse they saw or spoke to was good at involving them in decisions about their care and 94% found the receptionists helpful.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and all were very positive about the service experienced. Patients said the practice offered an excellent service and staff were warm, welcoming and caring. They said staff treated them with respect and were genuinely interested in their wellbeing.

This feedback was confirmed by all eleven patients we spoke with on the day our inspection. This included three members of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

However, we received feedback from other professionals (Nottingham City Clinical Commissioning group and midwives) that patients' privacy and dignity had not always been maintained when one of the treatment rooms was used; as patients entering the surgery could see into the room. In response to this, the practice had placed curtains in the room to ensure people's privacy but this did not cover the full length of the window and therefore the action may not effective.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the GP and practice manager.

Staff told us that people whose circumstances may make them vulnerable could access the practice without fear of stigma or prejudice. The GP gave an example of how staff had been supported on how to deal sympathetically with people experiencing poor mental health.

The practice telephone was located on the reception desk and was shielded by a sliding glass partition which helped keep patient information private. We saw that staff were careful to ensure that confidential information was kept private on most occasions. However, we observed an occasion where a patient was leaning through the reception desk hatch and confidential information was visible to them as the computer screen was tilted towards the hatch.

This was highlighted to practice staff to risk assess and address, so as to minimise the risks of breaching patient confidentiality. Staff we spoke with demonstrated awareness of the practice's confidentiality policy but had not received formal training on information governance which is essential to their role. The policy was also due for review in January 2015.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment; and rated the practice well in these areas. For example, data from the national patient survey showed 91% of practice respondents said the GP involved them in care decisions, 96% felt the GP was good at explaining treatment and results, and 89% said the GP was good at giving them enough time. Both these results were above average compared to CCG local average.

Patients we spoke with told us their health issues were discussed with them and they felt very much involved in decision making about the care and treatment they received. They also felt listened to and supported by staff

Good

Are services caring?

and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available and we were given examples where this had been used.

We requested for the practice's 2014/15 Quality Outcome Framework (QOF) data to review their performance in respect of care planning arrangements. The practice was unable to produce this data when requested therefore we had to rely on the 2013/14 data which may not be up to date. The QOF is a voluntary incentive scheme for GP practices that financially rewards practices for managing some of the most common long-term conditions.

The 2013/14 QOF data showed no identified risk in respect of care planning arrangements. For example, all the patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record in the preceding 12 months for example, and this was above the national average of 86.09%. We reviewed the care plans for seven patients on the learning disability register and five patients on the dementia register. We found evidence of patient involvement in agreeing the care plans.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 96% of respondents to the national patient survey said the last GP they saw or spoke to was good at treating them with care and concern. This was above the CCG average of 84%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. Two patients gave examples of how they had been supported to access services to help them manage their treatment and care when it had been needed.

Notices in the patient waiting room also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

We were shown the written information available for carers to ensure they understood the various avenues of support available to them. This included information on Nottingham Citycare carers support service and care services directory.

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

The GP told us people with long-term conditions were assessed for anxiety and depression where indicated. We saw that information on clinical psychology services, talking therapies and how to access free courses from the Nottingham Primary Health and Wellbeing college were available to patients in the wait area.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice took into account the needs of some of the population groups we inspected when planning services. For example, ante-natal care and well-baby clinics were facilitated every fortnight by the midwife and health visitor who worked closely with the practice.

A monthly multi-disciplinary meeting was held to discuss patients with complex needs or at risk of hospital admission. This included people with poor mental health, learning disabilities or those receiving end of life care. This meeting was attended by the care coordinator, district nurse and community matron. This ensured that patients and families received coordinated care and support.

The practice had not formally assessed how patient care was targeted between the GP and practice nurse to reduce the waiting time for patients to access services. We found patients had access to the locum practice nurse on Tuesdays and Wednesdays only; and in their absence this role was not covered. This meant services such as cervical screening, well woman checks, immunisations and travel vaccinations were only provided to patients when the nurse was present. This did not ensure flexibility and choice for patients.

The inspection history of the practice demonstrated that the practice's approach to meeting patients' needs was generally reactive to the outcomes of the Care Quality Commission inspections and Local Area Team visits.

We found key themes from previous inspections emerging which evidenced that action plans had not been fully implemented to secure sustainable improvements. This included maintaining sufficient staffing levels to meet patient needs and the administration of the practice.

Our initial inspection of the practice on 14 January 2014 identified that the low staffing levels had a moderate impact on patients' needs not being met. We re-inspected the practice on 14 August 2014 and found the provider had made sufficient improvements to meet the regulation requirements.

However, our current inspection findings showed the practice had limited workforce planning arrangements in place to ensure sufficient staff were in place to meet patients' current and future needs. For example, the locum nurse has been in post since October 2014 and no permanent post had been offered. The GP told us they were keen to employ an advanced nurse practitioner to support their role and had identified a suitable candidate following a recruitment process. However, no offer of employment had been given as the practice was still reviewing the financial viability of employing them.

Members of the patient participation group (PPG) that were present during the practice's presentation suggested the need for the practice to consider flexible working arrangements for potential staff and / or use of a recruitment agency to obtain suitable staff as this had not been considered by the practice.

A review of 19 patient records and scanned correspondence received between 02 and 09 April 2015 showed systems in place did not always ensure that test results, information from the out-of-hours provider and letters from the local hospital including discharge summaries were promptly seen, correctly coded and followed up by a GP or nurse, where required. This did not ensure that clinicians could plan appropriate care and treatment in a timely manner. This was a required improvement following a previous CQC inspection on 14 August 2014.

We found shortfalls in the delivery of services for the working age and recently retired population group. The practice population of patients aged between 25 and 50 years is above the national average. For example, telephone consultations were not routinely offered, and online facilities to book appointments and request prescriptions were not available.

The practice had implemented changes to the way it delivered services in response to feedback from the PPG. An example included staff making a side room available for patient to discuss confidential information. This was in response to patient feedback about being overheard in the waiting area. This room was available during our inspection.

Tackling inequity and promoting equality

The practice had recognised the needs of people with a disability and / or impairment, carers and people's whose first language was not English. The premises and services were accessible to meet the needs of patient with

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

disabilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams, and allowed for easy access to the treatment and consultation rooms.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice was situated on the ground floor of the building which made movement around the practice easier and helped to maintain patients' independence.

The practice had access to telephone and face to face translation services to cater for other different languages. The practice should consider providing staff with equality and diversity training through e-learning and / or discussing it at team events as we found this did not take place. The GP had recorded an audio file of the practice leaflet / service provision. This was available on the practice website however information on staff was not up to date.

The practice had a system in place for flagging vulnerability in individual patient records and the GP showed us a list of people living in vulnerable circumstances. This included children living in households with domestic violence and or non-English speaking families who may be at risk of isolation. The GP has developed positive relations with patients which allows continuity of care. The GP told us they preferred to use the same locum staff when needed so that patients were also familiar with them.

The practice actively supported patients who have been on long-term sick leave to return to work by providing sick notes. However, one patient record we looked at showed that an adequate assessment of the patient's condition had not been recorded when they attended a consultation to request a sick note.

Access to the service

The national patient survey results showed the practice's phone access was good and most patients were satisfied with the appointment system. For example, 91% of respondents found it easy to get through to the surgery by phone which was above the local CCG average of 75%. 97% said the last appointment they got was convenient and 81% described their experience of making an appointment as good

The survey results also showed that 18% of respondents usually waited 15 minutes or less after their appointment time to be seen. This meant that 72% of respondents waited more than 15 minutes to be seen by the GP. This was a feature of the open access system operated by the practice. We received mixed feedback from patients we spoke with on the day of our inspection.

Most patients were happy with the open access system in that they were guaranteed a same day appointment if they phoned the practice before 11:15am. They told us staff usually wrote their name on the waiting list, gave them an estimated time they would be seen and / or were called nearer their appointment time if they chose to wait at their home as they lived locally. These were our observations on the day of the inspection. Most patients felt being able to see the GP the same day was a reasonable compromise over a longer waiting time.

The PPG meeting minutes and 2013/14 practice patient survey showed that patients' concerns over the waiting time had been reviewed. The group felt that applying pressure on the GP to consult at a higher pace "should to some extent be resisted" as patient surveys results showed most patients were satisfied with the GP's consultations, and the waiting time was "reasonable in the circumstances".

The practice website clearly stated "there will be a delay in seeing the doctor, but you do not need to wait on the premises. We will give you a guide when you are likely to be seen. Patients over 80 and under 3 can arrange a time to come by phone".

Some working age people felt the appointment system needed review as it was not particularly useful due to work commitments. The opening hours of the practice were 8:30am to 6:30pm on weekdays; with pre-bookable appointments being available from 2:00pm to 6:30pm on weekdays. However, on average there was a two week wait to obtain a GP appointment for routine appointments.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments and home visits were available for patients who needed them, including older people and

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

people with long-term conditions. Patients under eleven and aged 75 and over were seen the same day. Appointments were available outside of school hours for children and young people. The GP told us the mental health needs of the practice population were monitored and flexible services and appointments were offered. This included avoiding booking appointments at busy times for people who may find this stressful.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. However this had not been updated since October 2014 and names of former staff had not been amended. The GP had overall responsibility for handling all complaints in the practice.

Five out of 11 patients we spoke with told us they were not aware of the process to follow if they wished to make a complaint as information was not publicised in a suitable manner and format. We found there were no leaflets within the waiting area to inform patients of the practice's complaints process. However, we saw one poster displayed at the reception desk drawing patients' attention on how to make a complaint.

The practice reported it had not received any complaints within the last twelve months. 10 out of 11 patients we spoke with told us they had never made a complaint and had no reason to. One person told us they had made a verbal complaint but chosen not to take it further; but this had not been recorded on the practice records.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The GP told us their overall vision was to facilitate positive outcomes for patients and they worked hard to maintain this. However, we found the practice did not have a clearly defined strategy and supporting objectives to achieve this vision.

The GP told us factors such as staffing shortages, work overload and funding significantly impacted on their ability to develop a clearly defined vision and strategy within their working time. We found limited evidence to confirm how these factors would be addressed to ensure the GP could devote more time to the leadership of the practice.

Most of the staff we spoke with were not aware of the practice vision and said management had not discussed it with them as a team. The staff told us their daily aim was to provide a good service for patients and provide the GP with support. They acknowledged high levels of workload and working overtime hours.

The GP and staff shared strong values of providing a caring and friendly service that prioritised person centred care, openness and easy access for patients. Staff we spoke with were able to explain their understanding of these values and how they would promote them to provide good care for patients.

Governance arrangements

Staff did not have appropriate policies to guide them in carrying out their roles. For example: policies were very brief or had not been reviewed and updated within the provider's stipulated timeframe; and in some cases were not being followed in practice. This included areas such as recruitment, significant events, infection prevention and control. Most staff had not completed a cover sheet to confirm they had read the provider's policies.

There was a clear leadership structure with named members of staff and the GP held most of the lead roles. For example, safeguarding, infection control and medicines management. We were concerned about the sustainability of this arrangement. The GP faced significant challenges in maintaining an overview of their lead roles whilst at the same time covering staff absence and ensuring the delivery of their own clinical responsibilities.

Our evidence demonstrated that the systems in place to ensure the GP could assess and monitor the quality of the service; and identify, assess and manage risks were not effective as their limited resources were stretched too thinly.

The staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns. One of the reception staff was clear about their own roles and responsibilities given they had worked in the practice since December 2014. Another member of staff had joined the practice a week before our inspection therefore was still undertaking induction.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results The QOF data for this practice showed it was performing in line with national standards. The practice had achieved 93.6% for the 2013/14 QOF data. We found this data was not regularly discussed at practice meetings and action plans were not produced to maintain or improve outcomes.

The practice did not actively participate in a local peer review system with neighbouring GP practices to measure its service against others and identify areas for improvement. Although the practice had undertaken reviews of some aspects of patient care such as respiratory medicine in asthma patients and cow's milk protein allergy in child's health; it did not have an on-going programme of clinical audits which it used to monitor quality and systems, as well as to identify where action should be taken.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice had engaged with them to discuss local needs and areas that needed to be prioritised; however limited service improvements had been achieved.

Leadership, openness and transparency

We have inspected this practice on four occasions since they registered with us. On three of the occasions we have set requirements as the provider was not meeting legal requirements in respect of how they delivered the service. Our findings at this inspection meant we could not be

Are services well-led?

Inadequate

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

confident that the GP had appropriate knowledge of the law and legal requirements, and understood the consequences of failing to take effective action to meet previously set requirements.

Since our last inspection in November 2014 we found there had been no recent review of governance and performance management. Our evidence indicated there was insufficient leadership capacity to lead the practice effectively. For example, the GP undertook nine sessions a week and on average saw 15 patients in the morning and seven patients in the afternoon. The GP was also lead for all clinical areas.

The practice manager was relatively new in post and expressed a commitment to supporting the GP to make improvements. However, they acknowledged having limited time to undertake their management role as they covered reception duties in the interim of additional staff commencing employment and supported new staff with induction.

We spoke with the GP and practice manager about the concerns we found during our visit. One of the concerns we discussed was about staffing levels. This has been a significant theme from previous inspections we undertook on 14 January 2014, 14 August 2014 and 10 November 2014.

At our last inspection, the GP expressed difficulty in recruiting a second GP partner but we found no active recruitment / succession plans in place and the GP acknowledged they may not need another partner. However, it was not clear to us how the GP planned to manage and / or balance their clinical role and governance role if they did not recruit another clinical staff member.

There were high levels of work overload due to staff shortages (clinical and administration staff). Staff told us this resulted in delays in processing patient information of which we noted. Some patients were reported as being referred to the walk in centre for dressings when the nurse was not working at the practice. This reflected a lack of robust systems in place to monitor patients' needs and outcomes.

The practice has experienced high staff turnover since September 2014 and the GP admitted to inflexibility in his expectations; for example flexible working hours and staff who did not share the same ethos as him.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with the practice manager and / or GP. We were shown the policy folder available to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and comment cards. We looked at the results of the 2013/14 annual patient survey and 90.57% of patients agreed the waiting time was reasonable and as a result the practice did not change the open access appointment system.

The practice had a patient participation group (PPG) which met with the GP to discuss service improvement. We found limited evidence of regular patient involvement in the practice as they met at the most twice a year.

Staff feedback was gathered through discussions and no staff meetings were held. The management told us this was due to the practice team being small at present. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they were committed to improving outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the policies folder but was due for review in January 2015.

Management lead through learning and improvement

The practice GP was responsible for clinical leadership and governance. We found clinical staff were not supported to maintain their professional development through training, supervision or mentoring. The GP did not have insight into his accountability for clinical supervision for the locum GP and nurse; and poor performance was not acted on in a timely way.

This had resulted in the poor assessment and lack of recording in patient records accessed by the locum GP. For example, two patients who had attended for a consultation on 30 March 2015 did not have any clinical notes in their records therefore we could not ascertain what care and

Are services well-led?

Inadequate

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

treatment they had received. In addition, the records of three patients seen the same day showed an adequate assessment had not been completed and a working diagnosis had not been recorded.

We found no recorded induction and supervision for any of the staff, although staff felt there were well supported by the GP and practice manager. The practice manager confirmed this happened informally and they had limited time to undertake this role due to staff shortages. No appraisals had taken place as all staff had not been employed for over a year.

We found the practice had limited systems in place to provide essential training for staff that was relevant to their roles. The practice manager told us staff they only accessed training provided by the Clinical Commissioning Group.

Staff we spoke with gave three examples of significant events that had occurred but there was no documented evidence to show that the practice had completed a review of the significant events to ensure improved outcomes for patients and staff. We found minimal evidence of shared learning and reflective practice. We also found no evidence of innovation, service development and improvement of performance.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: We found the registered person had not protected people against the risks of receiving inappropriate care and treatment by carrying out an appropriate assessment and review of the health and medicines needs. Regulation 9(3)(a)(b)(d).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found the registered person did not have suitable arrangements in place for assessing risks relating to health and safety and infection control. Regulation 12(1)(2)(h).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: We found the registered person did not have effective governance, assurance and auditing processes to monitor the service; and ensure that records relating to the care and treatment of patients were fit for purpose. Regulation 17(1)(2)(a)(b)(c).

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: We found the registered person had not ensured sufficient numbers of suitably qualified staff had been employed and supported with appropriate training, professional development and supervision to enable them to carry out their duties. Regulation 18(1)(2(a)(b).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found the registered person had not protected people against the risk of unfit staff. The practice did not operate robust recruitment procedures including undertaking appropriate pre-employment checks. Regulation 19(1)(a(b)(c)(2)(4).