Priory Avenue Surgery

Quality Report

2 Priory Avenue
Caversham
Reading
RG4 7SF
Tel: 01189 472431
Website: www.prioryavesurgery.co.uk

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Priory Avenue Surgery on 26 January 2017. The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months.

On 2 June 2017 we carried out a focused inspection at Circuit Lane Surgery to determine whether the practice was meeting the conditions applied following the January inspection.

The outcome of this inspection was that three out of six conditions imposed were removed. The current conditions in place during this inspection were:

- The registered person must implement a sustainable system to ensure outstanding and future repeat prescription requests, medication reviews, clinical correspondence and paper medical records requiring summarisation are reviewed and actioned without delay, to ensure patients are protected from risk of harm, at Priory Avenue Surgery. The existing backlogs for repeat prescription requests, medication reviews, clinical correspondence must all be cleared by 1st March 2017.The summarisation of paper records must be completed by 15th March 2017.
- The registered provider must ensure adequate capability, resource and capacity of all staffing groups in order to deliver a safe service. This includes providing adequate clinical staffing and appointments at Priory Avenue Surgery at all times to protect the health and welfare of patients .
- Effective and sustainable clinical governance systems and process must be implemented by 15th March 2017 at Priory Avenue Surgery. This is to ensure that all patients are able to access timely, appropriate and safe care; the systems and processes implemented protect patient safety and enable compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Both reports from the January 2017 and June 2017 inspections can be found by selecting the 'all reports' link for Priory Avenue Surgery on our website at www.cqc.org.uk. The practice has been managed by One Medicare Limited since September 2016 and they are registered to provide the services and this practice.

Summary of findings

This inspection was undertaken following the period of special measures and was an announced comprehensive inspection on 10 October 2017. Overall the practice is now rated as requires improvement.

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.

Our key findings were as follows:

- There was a system in place for reporting and recording significant events. However, this did not include a means of identifying patients involved in the event.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, we found staff had acted as chaperones without the appropriate knowledge of how to undertake this appropriately.
- The practice did not maintain appropriate standards of cleanliness and hygiene. We observed some areas of the treatment room and clinical rooms and the non-clinical areas on the ground floor of the premises to be dirty with a thick layer of dust. There was no cleaning schedule in place on the day of inspection.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment.
- The practice had adequate arrangements in place to respond to emergencies and major incidents.
- The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent data from 2016/17 showed positive performance within the current QOF year (ending in March 2017).
- The practice had a clear and safe procedure for medicine reviews.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. The systems for supervision of clinical staff did not ensure that new team members always felt supported in their role.
- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.
- Staff sought patients' consent to care and treatment in line with legislation and guidance. Although further understanding of the Mental Capacity Act 2005 was needed.
- We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Results from the national GP patient survey were mixed. The practice was below average for its satisfaction scores on consultations with GPs and nurses.
- Friends and family test results showed that patient satisfaction had increased since January 2017 then decreased in September 2017.
- Patients told us they felt involved in decision making about the care and treatment they received.
- The practice had an effective system in place for handling complaints and concerns.
- The provider's vision to deliver high quality care and promote good outcomes for patients but this was not always supported by effective leadership and governance processes.
- There were arrangements for identifying, recording and managing risks within the practice; however, some risks were not identified.
- Clinical meetings were not consistently carried out and documented.
- Practice specific policies were implemented and were available to all staff. Although not all policies were followed, such as the chaperone policy.
- The practice had used most of their resources since the inspection in January addressing the areas of high risk and the clinical and administrative backlog. This had resulted in little opportunity for innovation or service development. There was also minimal evidence of learning and reflective practice.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Summary of findings

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

This service was placed in special measures in January 2017. Insufficient improvements have been made such that there remains a rating of inadequate for well-led. Therefore the service will remain in special measures. The service will be kept under review and if needed could be escalated to urgent enforcement action. Another inspection will be conducted within six months, and if there is not enough improvement we may move to close the service.

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?

Requires improvement

- There was a system in place for reporting and recording significant events. However, this did not include a means of identifying patients involved in the event.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, we found staff had acted as chaperones without the sufficient knowledge of how to undertake this appropriately.
- The practice did not maintain appropriate standards of cleanliness and hygiene. We observed the treatment and clinical rooms on the ground floor of the premises to be dirty. There was no cleaning schedule in place on the day of inspection.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment.
- The practice had adequate arrangements in place to respond to emergencies and major incidents.

Are services effective?

Requires improvement

- The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent data from 2016/17 showed positive performance within the current QOF year (ending in March 2017).
- The practice had a clear and safe procedure for medicine reviews.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. However, new roles within the practice had not been fully supported and given the appropriate clinical supervision.
- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.
- Staff sought patients' consent to care and treatment in line with legislation and guidance. Although further understanding of the Mental Capacity Act 2005 was needed.

Summary of findings

Are services caring?

Requires improvement

- We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Results from the national GP patient survey were below both CCG and national averages. The practice was below average for its satisfaction scores on consultations with GPs and nurses.
- Friends and family test results showed that patient satisfaction had increased since January 2017 then decreased in September 2017.
- Patients told us they felt involved in decision making about the care and treatment they received.
- Results from the national GP patient survey showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment. Results were below the local and national averages.

Are services responsive to people's needs?

Requires improvement

- The practice was open between 8am and 6.30pm Monday to Friday. Additional appointment times were available until 7pm on Wednesdays and Thursdays and on two Saturdays a month between 8.30am and 12.30pm.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.
- For example: 24% of patients said they could usually get to see or speak to their preferred GP compared the CCG average of 64% and the national average of 56%.
- The practice had an effective system in place for handling complaints and concerns.

Are services well-led?

Inadequate

- The provider's vision to deliver high quality care and promote good outcomes for patients was not always supported by effective leadership and governance processes.
- Governance systems did not fully support the delivery of safe, effective and responsive care.
- There were arrangements for identifying, recording and managing risks within the practice; however, some risks were not identified.
- We found shortfalls in systems and process for making sure that the premises was cleaned and safe to provide care and treatment in. There was no cleaning schedule in place and the systems in place had not identified and rectified the issues regarding cleanliness within the practice.

Summary of findings

- Improvements were also needed in supervision of staff and ensuring clinical meetings were held regularly and documented.
- The practice had used most of their resources since the inspection in January addressing the areas of high risk and the clinical and administrative backlog. This had resulted in little opportunity for innovation or service development. There was also minimal evidence of learning and reflective practice.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated as requires improvement for safety, effective, caring, responsive and inadequate for well-led services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- There was a system to prioritise older patients for appointments.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- We saw hospital admissions, letters from specialists and paramedic correspondence was now acted on promptly which reduced the risks for this population group.
- The practice identified older patients and coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for patients approaching the end of life.
- We saw unplanned hospital admissions and re-admissions for the over 75's were regularly reviewed and improvements made.
- Data showed that outcomes for patients for conditions commonly found in older people were within the target range. For example, 100% of patients diagnosed with dementia had their care reviewed in the last 12 months.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for the care of people with long-term conditions. The provider was rated as requires improvement for safety, effective, caring, responsive and inadequate for well-led services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Patient correspondence from external providers, such as hospital and paramedics, was with in a timely way.
- Patients reported improvements in issuing repeat prescriptions.
- The practice employed a pharmacist to assist with the health and medicines reviews of patients with long term conditions. For patients on less than four medicines 48% had an up to date medication review. For patients on four or more medicines 75% had an up to date medicine review.

Summary of findings

- Data for diabetes related indicators showed achievement of 100% for 2016/2017.
- Longer appointments and home visits were available when needed.
- For those patients with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. However, patients felt that there was a lack of continuity of care which impacted on the management of their health needs.
- Unverified data for chronic obstructive pulmonary disease (COPD, a condition which causes breathing difficulties) indicators showed the practice had achieved 92% of patient annual reviews.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for the care of families, children and young people. The provider was rated as requires improvement for safety, effective, caring, responsive and inadequate for well-led services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's unverified uptake for the cervical screening programme was 100%, which was above the expected achievement of 80%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated as requires improvement for safety, effective, caring, responsive and inadequate for well-led services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The surgery offered extended late appointments every Tuesday and Wednesday until 7pm and on Saturday mornings.
- The practice was proactive in offering online services for repeat prescriptions as well as a range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement 

The provider was rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as requires improvement for safety, effective, caring, responsive and inadequate for well-led services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered longer appointments for patients with a learning disability.
- Practice staff were trained to recognise signs of abuse within their vulnerable patients.
- GPs worked within a multi-disciplinary team to ensure the best outcomes for vulnerable patients. The practice worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to 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 how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The provider was rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as requires improvement for safety, effective, caring, responsive and inadequate for well-led services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

Summary of findings

- Data showed 92% of patients diagnosed with a severe mental health issue had a comprehensive agreed care plan in place.
- Data showed 100% of patients diagnosed with dementia had a comprehensive agreed care plan in place.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice carried out advance care planning for patients living with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and those living with dementia.

Priory Avenue Surgery

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 CQC GP specialist advisor, a second CQC inspector, a nurse specialist advisor and an expert by experience.

Background to Priory Avenue Surgery

Priory Avenue Surgery provides primary medical services to the Caversham area of Reading from a two-storey converted dwelling, which has undergone several extensions over the last 10 years.

There are no onsite parking facilities and the local roads have available parking for restricted times. There is one parking space adjacent to the practice for patients with limited mobility. The consultation and treatment rooms are on both the ground and first floors with three waiting areas. The first floor can only be reached by a staircase, with no lift facility currently in place.

There are approximately 6,800 patients registered with the practice. This had reduced from 8,000 when we last inspected. The practice serves a population in an area of mainly average deprivation but with some pockets of low deprivation. The practice has a larger number of patients aged 30 to 49 than other practices nationally. The number of patients over the age of 65 is similar to the national average.

One Medicare Ltd took over the contract following a procurement exercise led by the local clinical commissioning group in September 2016.

At the time of the inspection the service offers 3.3 whole time equivalent (WTE) GPs, 1 WTE advance nurse practitioner (ANP), 1 WTE practice nurse and 0.4 WTE health care assistant sessions every week. There were male and female GPs available. The practice has an Alternative Provider Medical Services (APMS) contract.

When the practice is closed, out-of-hours (OOH) GP cover is provided by the Westcall OOH service. Notices on the entrance door, in the patient leaflet and on the practice website clearly inform patients of how to contact the OOH service.

All services are provided from: 2 Priory Avenue, Caversham, Reading, Berkshire, RG4 7SF.

Why we carried out this inspection

We undertook a comprehensive inspection Priory Avenue Surgery in January 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe, effective, responsive and well led services and was placed into special measures for a period of six months.

We also imposed urgent conditions upon the provider's registration. We undertook a follow up inspection on 1 June 2017 to check that action had been taken to comply with legal requirements. The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Priory Avenue Surgery on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of Priory Avenue Surgery on 10 October 2017.

Detailed findings

This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice could come out of special measures.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as health watch and, the clinical commissioning group and NHS England to share what they knew. We carried out an announced visit on 10 October 2017. During our visit we:

- Spoke with a range of staff including GPs, an advanced nurse practitioner, pharmacists, an emergency care practitioner, the practice manager, and several members of the administration and reception team.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed two comment cards where patients and members of the public shared their views and experiences of the service and spoke to 31 patients.
- Looked at information the practice used to deliver care and treatment plans.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Requires improvement

Are services safe?

Our findings

At our previous inspection in January 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of procedures and equipment for dealing with emergencies, processing or repeat prescriptions in a timely manner and staffing levels were not adequate.

A further unannounced focused inspection was carried out on 1 June 2017 to check that the practice was complying with the conditions imposed upon their registration arising from the breaches in regulations that we identified in our previous inspection on 26 January 2017. Three of the six conditions imposed were removed following this inspection.

We found arrangements had improved when we undertook a follow up inspection on 10 October 2017. The practice is now rated as requires improvement for providing safe services.

Safe track record

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a reporting system online which enabled the onsite and offsite leadership teams to have an overview of the significant events.
- The reporting system at Priory Avenue Surgery did not record a patient identifier which resulted in the practice being unable to identify patients detailed in the log. We saw evidence this was rectified within 24 hours of our inspection.
- We saw some evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. However, we saw an example where the patient had not been contacted following them reporting a significant event to the practice in June 2017.
- The practice carried out an analysis of the significant events.
- The practice staff had daily 'huddles' where they shared any relevant information with the team. However, clinical meetings had not taken place routinely since our last inspection. There were no minutes available from these clinical meetings to evidence how learning was disseminated to all the relevant staff. Staff we spoke with on the day of inspection were aware of and could discuss significant events.

Reliable safety systems and processes including safeguarding

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three, nurses were trained to level two and non-clinical staff were trained to level one.
- A notice in the waiting room advised patients that chaperones were available if required. Not all staff who acted as chaperones were sufficiently trained for the role, however, all had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had a training session planned for the end of October to ensure all staff would be appropriately trained. On the day of the inspection, the practice confirmed that, with immediate effect, only staff that were trained would chaperone patients until all relevant staff had been trained.
- The practice did not maintain appropriate standards of cleanliness and hygiene. We observed some areas of the premises to be dirty. Specifically the treatment room and downstairs consulting rooms and the non-clinical

areas had a thick layer of dust. We saw dust on the spill kit and anaphylaxis kit (to treat allergic reactions) was dusty and sticky. There was no cleaning schedule in place on the day of inspection.

- The lead practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Blank prescription stationery was stored in accordance with current guidelines and was only accessible to practice staff. Staff completed a log which detailed what prescriptions were received by the practice and recorded when, where, to which GPs received prescription stationery. However, we found that serial numbers of computer prescription forms distributed within the practice on the log did not match the stock the practice had on the day. The practice reviewed the process and they corrected the log sheet on the day of the inspection.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (A PGD is a written instrustion for the supply and/or administration of a named licensed medicine for a defined clinical condition. Their use allows a registered health care professional to administer a prescription only medicine to a group of patients who fit the criteria without them necessarily seeing a prescriber).
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring safety and responding to risk

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- All staff received annual basic life support training and there were emergency medicines available on site.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.
- 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.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in January 2017, we rated the practice as requires improvement for providing effective services as there was a significant backlog of patient correspondence and referrals, including significant delays in providing patients with timely care and treatment.

A further unannounced focused inspection was carried out on 1 June 2017 to check that the practice was complying with the conditions imposed upon their registration arising from the breaches in regulations that we identified in our previous inspection on 26 January 2017. Three of the six conditions imposed were removed following this inspection.

We found arrangements had improved when we undertook a follow up inspection of the service on 10 October 2017. The practice is still rated as requires improvement for providing effective services.

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.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent data from 2016/17 showed average performance within the current QOF year (ending in March 2017). For example:

- Performance for chronic obstructive pulmonary disease related (COPD) indicators showed the practice had achieved 92% compared to the CCG average of 95% and the national average of 96%.
- Performance for mental health related indicators showed the practice had achieved 92% compared to the CCG average of 92% and the national average of 94%.
- Performance for diabetes related indicators showed the practice had achieved 92% compared to the CCG average of 92% and the national average of 91%.
- Performance for asthma related indicators showed the practice had achieved 100% compared to the CCG average of 96% and the national average of 97%.
- Performance for dementia related indicators showed the practice had achieved 100% compared to the CCG average of 98% and the national average of 97%.
- Overall performance showed the practice had achieved 98% compared to the CCG average of 95% and the national average of 96%.

Overall exception reporting was 5% (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).

- Exception reporting for chronic obstructive pulmonary disease related (COPD) indicators showed the practice had achieved 5%.
- Exception reporting for mental health related indicators showed the practice had achieved 4%.
- Exception reporting for diabetes related indicators showed the practice had achieved 7%.
- Exception reporting for asthma related indicators showed the practice had achieved 0.4%.
- Exception reporting for dementia related indicators showed the practice had achieved 5%.

Patients had regular reviews to make sure their medicines were still needed and effective.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff administering vaccines received specific training. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by discussion at nurse meetings.
- There had been two new roles introduced within the practice which included clinical pharmacists and an emergency care practitioner (a qualified paramedic). Staff reported there was a lack of onsite clinical supervision and clear guidance on what duties they were expected to perform. Following the inspection the practice told us the new clinical lead would take over the ongoing supervision of these staff members.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff did not always have access to appropriate training to meet their learning needs and to cover the scope of their work. All staff had an appraisal scheduled.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Working with colleagues and other services

The information needed to plan and deliver care and treatment 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.

Consent to care and treatment

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

- Most staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. However, we found that some team members did not show full understanding of their responsibilities in relation to MCA. The practice told us they had arranged a face to face session with the provider lead for MCA, to improve knowledge within the practice.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Health promotion and prevention

The practice identified patients who may be in need of extra support. For example:

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

The practice's uptake for the cervical screening programme was 100% which was comparable to the national average of 82%.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Breast cancer screening uptake was 70%, compared to the national average of 72%. Bowel screening uptake was 41%, which is lower than the national average of 58%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The latest available childhood immunisation rates for the vaccinations given to children registered with Priory Avenue Surgery showed: childhood immunisation rates for the vaccinations given to under two year olds ranged from 83% to 97% and five year olds from 90% to 97%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Requires improvement

Are services effective?

(for example, treatment is effective)

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

At our previous inspection in January 2017, we rated the practice as requires improvement for providing caring services patient satisfaction was low.

A further unannounced focused inspection was carried out on 1 June 2017 to check that the practice was complying with the conditions imposed upon their registration arising from the breaches in regulations that we identified in our previous inspection on 26 January 2017. Three of the six conditions imposed were removed following this inspection.

We found that satisfaction was still low and had not been responded to by the practice when we undertook a follow up inspection on 10 October 017. The practice is still rated as requires improvement for providing caring services.

Respect, dignity, compassion and empathy

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues they could offer them a private room to discuss their needs.

All of the two patient Care Quality Commission comment cards we received had positive comments about the service experienced.

We spoke to 31 patients and they reported mixed experiences. Most patients reported that their repeat prescription were provided within 48 hours. A total of 15 patients said that their appointment was usually late by around 20 minutes to 40 minutes with no explanation of why.

Results from the national GP patient survey were below CCG and national averages. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 86%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%
- 73% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 86%.
- 83% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Friends and family test results showed that patient satisfaction had increased since January 2017 then decreased in September 2017:

- In September 2017, 59% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 23% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In August 2017, 69% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 19% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In June 2017, 60% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 25% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In April 2017, 62% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 18% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In January 2017, 53% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 31% were unlikely or extremely unlikely to recommend the practice to their friends and family.

Requires improvement

Are services caring?

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. We also saw that care plans were personalised.

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

- 77% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 73% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 64% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

The practice could not evidence any action plans of how they were planning to respond to the patient survey results.

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.
- The practice had a portable hearing loop.

Patient/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 95 patients as carers (1.3% of the practice list).

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was followed by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection in January 2017, we rated the practice as inadequate for providing responsive services as the arrangements in respect of responding to patient feedback were insufficient to ensure changes are implemented.

A further unannounced focused inspection was carried out on 1 June 2017 to check that the practice was complying with the conditions imposed upon their registration arising from the breaches in regulations that we identified in our previous inspection on 26 January 2017. Three of the six conditions imposed were removed following this inspection.

We found arrangements had improved when we undertook a follow up inspection of the service on 10 October 2017. However, further improvements were required to ensure patient satisfaction was reviewed and responded to. The practice is now rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

- The practice offered extended hours to meet the needs of their working age population.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There was a hearing loop and translation services available.
- Arrangements were not in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. In July 2017 patients reported a one to two week wait for a routine appointment, in August and September 2017 they reported a three to four week wait and in October 2017 they reported a four week wait.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Additional appointment times were available until 7pm on Wednesdays and Thursdays and on two Saturdays a month between 8.30am and 12.30pm.

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

The practice had a system in place to assess:

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

For example, by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

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

- 68% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 76%.
- 73% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and national average of 71%.
- 81% of patients said they were able to get an appointment compared to the CCG average of 86% and the national average of 84%.
- 24% of patients said they could usually get to see or speak to their preferred GP compared the CCG average of 64% and the national average of 56%.

The practice could not provide evidence of action plans to address the lower satisfaction results.

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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example there was a summary leaflet was available at reception

We looked at 10 complaints received in the last 12 months and found these were satisfactorily handled in a timely way, with lessons learned and apologies given to the complainant. For example, when a patient complained about the length of time taken for a repeat prescription, the practice management investigated the complaint and provided a verbal and written apology to the patient.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection in January 2017, we rated the practice as inadequate for providing well-led services as there was no vision or strategy for the practice, no overarching governance structure and no clear leadership arrangements.

A further unannounced focused inspection was carried out on 1 June 2017 to check that the practice was complying with the conditions imposed upon their registration arising from the breaches in regulations that we identified in our previous inspection on 26 January 2017. Three of the six conditions imposed were removed following this inspection.

We found arrangements had improved when we undertook a follow up inspection of the service on 10 October 2017. The practice is still rated as inadequate for being well-led.

Vision and strategy

The provider's vision to deliver high quality care and promote good outcomes for patients was not always supported by effective leadership and governance processes. At the time of inspection, evidence confirmed that the level of care and quality outcomes for patients had improved since the inspection in January 2017. However, patient satisfaction and appointment availability had started to decline since September 2017.

One Medicare Limited communicated a passion and drive to improve services provided in the practice. They had recently recruited a new manager who was in the process of further improving governance arrangements. We found additional breaches of regulation that had not been identified by the practice prior to inspection. There was no evidence of sustained improvement in all processes to identify and mitigate risks within the practice.

Governance arrangements

The practice had a governance framework but this did not fully support the delivery of safe, effective and responsive care. There were arrangements for identifying, recording and managing risks within the practice, but these did not identify all risks.

We found actions to mitigate the high level risks found during the January inspection had resulted in:

- a reduction in the time taken for the turnaround of repeat prescriptions.
- test results being reviewed in a timely manner.
- the backlog of patient administration requiring action had been cleared.
- clinical patient outcomes were positive, particularly regarding management of long-term conditions.

However some of the actions to mitigate other risks had not made sufficient improvements to the levels and quality of services provided to patients. For example:

- Systems and processes to ensure services were provided in a clean and hygienic environment were not effective. For example, there were no cleaning schedules in place and we found areas of the premises were dirty.
- The systems for supervision of clinical staff did not ensure that new team members were supported in their role and appropriately supervised.
- Clinical meetings were not held on a regular and planned basis. We found that when meetings were held these were not documented to enable the practice to demonstrate what had been discussed to demonstrate learning needed and monitoring of services provided.
- The practice chaperone policy was for trained to staff to undertake chaperone duties. Staff told us on the day of inspection that they would chaperone, even though they had not had training.
- Infection control procedures and audits did not identify the issues regarding cleanliness and the risk this may pose to patients.

There was a staffing structure and most staff were aware of their own roles and responsibilities, except for those newly appointed clinical roles. Practice specific policies were implemented and were available to all staff.

Leadership, openness and transparency

On the day of inspection the provider told us they prioritised safe, high quality and compassionate care. Staff told us the managers were approachable and took the time to listen to members of staff.

We saw some evidence the provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of

Are services well-led?

Inadequate

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

services must follow when things go wrong with care and treatment). However, we identified one patient with no documented communication following a significant event review.

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and staff mostly felt supported by management.

- Staff told us the practice did not hold regular team meetings other than the 'huddles'.
- Staff told us there was more of an open culture within the practice and they had the opportunity to raise any issues with the manager.
- Staff said they felt respected, valued and supported, particularly by the practice manager in the practice. Staff were now being involved in discussions about how to run and develop the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. The practice told us they had tried to conduct an in house patient survey but had not had any responses from patients.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team.
- The practice did not have any action plans in place to address the low patient satisfaction from the GP patient survey and the drop in the friends and family test over the last month.
- The practice told us they were in discussion with the local clinical commissioning group regarding the current funding levels to increase clinical capacity.

Management lead through learning and improvement

- The provider had spent the previous six months implementing changes to respond to the high levels of risk found at the inspection in January 2017. This has resulted in improved patient clinical outcomes for patients.
- The practice had used most of their resources since the inspection in January addressing the areas of high risk and the clinical and administrative backlog. This had resulted in little opportunity for innovation or service development. There was also minimal evidence of learning and reflective 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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure staff were appropriately trained and had sufficient knowledge to undertake chaperoning duties safely.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The system for ensuring staff were able to work with patients was not ensuring all the required ongoing registration checks were in place. • The systems and arrangements in place had not ensured the risk of, and preventing, detecting and controlling the spread of infections were being assessed, monitored and mitigated effectively. The CQC inspection team found the practice did not maintain appropriate standards of cleanliness and hygiene. We observed some areas of the premises to be dirty. Specifically the treatment room and downstairs consulting rooms and the non-clinical areas had a thick layer of dust. We saw dust on the spill kit and the anaphylaxis kit (to treat allergic reactions) was dusty and sticky. • We found two clinical members of staff did not have the appropriate knowledge regarding their responsibility to adhere to the Mental Capacity Act 2005. • The systems for supervision of clinical staff did not ensure that new team members were supported in their role and appropriately supervised. Staff reported there was a lack of onsite clinical supervision and clear guidance on what duties they were expected to perform. Three staff members told us had not had clinical supervision or a review of the standard of their work since commencing employment. • We were told clinical meetings were not held on a regular and planned basis. We found that when meetings were held these were not documented to enable the practice to demonstrate what had been discussed to demonstrate learning needed and monitoring of services provided.