Barnsley Road Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Barnsley Road Surgery on 13 October 2015. Overall the practice is rated as inadequate.

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

- Staff generally understood and fulfilled their responsibilities to raise concerns and to report incidents, near misses and any identified safeguarding issues.
- Staff had received role specific training to improve and extend services for patients.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were available for patients the same day as requested, although not necessarily with a GP of their choice.
- Patients said they were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice acted on feedback from patients through complaints, NHS Choices website GP national survey and the Friends and Family test and had focused on improving the patient experience of the services provided.

The areas where the provider should make improvement are:

- Ensure staff receive annual appraisals.
- Ensure there is access for patients with mobility difficulties and/or wheelchair users.
- Ensure clinical staff receive supervision.
- Ensure there is written information available for carers so they understood the various avenues of support available to them.
- Ensure there is a Patient Participation Group.

The provider must make improvements in the following areas:

- The practice had limited formal governance arrangements.

Summary of findings

- Systems and processes were not in place to assess, monitor and mitigate risks to patients. Incidents were not always recorded and significant events were not reported to the appropriate authorities. A fire risk assessment had not been completed annually. Fire drills had not been carried out. There was no ongoing programme of clinical audits to monitor quality and systems and identify where action should be taken. There was no system in place for recording verbal complaints.
- There were policies in place, however there were no dates of implementation or review dates.
- The practice did not have a system to share information about new clinical guidelines produced by the National Institute for Health and Care Excellence (NICE).
- Processes to ensure the safe storage of vaccines were applied inconsistently and records were not adequately maintained. Appropriate action had not been taken to mitigate risk when vaccines had been exposed to temperatures above recommended levels.
- The practice did not have oxygen for dealing with emergencies
- Systems and processes for infection prevention and control (IPC) were not adequate.
- Staff had not received training or regular updates relevant to their role such as, health and safety, fire safety, consent, information governance, safeguarding vulnerable adults and children and infection prevention and control.
- Disclosure and barring checks (DBS) had not been undertaken for health care assistants, Salaried GP and non clinical staff. Non clinical staff and a healthcare assistant acted as chaperones. The practice had made the decision not to carry out a DBS check for the non clinical staff, and could not provide a clear rationale as to why.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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. Staff generally understood and fulfilled their responsibilities to raise concerns and to report incidents, near misses and any identified safeguarding issues. Lessons were learned and communicated to support improvement. However, the practice did not have an effective system for reporting and recording significant events. We found some incidents had not always been reported. For example, there were numerous gaps in the daily monitoring of fridge temperatures. This had not been reported to NHS England.

Annual fire risk assessments were not undertaken. We saw a fire risk assessment had been completed in November 2012. However, actions taken did not align with our findings on the day of inspection. For example, fire drills had not been undertaken and evacuation plans had not been rehearsed regarding assisting patients and

Arrangements to safeguard adults and children from abuse were not adequate in relation to staff training and clarity of lead roles. The GP lead for safeguarding had not received level three training. There was a system in place to identify patients considered to be at risk. Staff demonstrated they understood their responsibilities and told us they would report safeguarding concerns to the practice manager.

Risks to patients and others were higher than necessary as systems to assess, monitor and mitigate risks, such as, risk assessments and appropriate training had not been provided for all staff. There were procedures for the management of medicines in the practice. However, there were some shortfalls in the monitoring of the temperatures of the vaccination refrigerators to ensure safe storage.

Recruitment arrangements did not include all necessary employment checks for staff in that there were no Disclosure and Barring (DBS) checks for healthcare assistants, the Salaried GP and non clinical staff who acted as chaperones. There were no risk assessments in place.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. Staff had received role specific training to improve and extend services for patients. However, they had not received training such as health and safety including fire safety, information governance, consent, safeguarding vulnerable

Summary of findings

adults and children and infection prevention and control. The practice encouraged an open door policy where staff received informal support. Staff did not receive annual appraisals and there was no process for the nurse to receive clinical supervision. Staff we spoke with confirmed they generally felt supported, had informal meetings with their manager and could request training.

There was no formal system to share information about new clinical guidelines produced by the National Institute for Health and Care Excellence (NICE).

Clinical audits were not used routinely to monitor the quality of the service and practice, there was no evidence of two cycle audits.

Staff worked with multidisciplinary teams to provide effective care and support to patients, improve outcomes and share best practice. The practice had implemented CCG initiatives to improve the care for patients. For example, the Prime Ministers' Challenge (this involves providing four extra appointments per week at the surgery and patients can also access appointments at Sheffield satellite practices).Data showed patient outcomes were average compared to other local practices.

Are services caring?

Requires improvement

The practice is rated requires improvement for providing caring services. There was no written information available for carers to ensure they understood the various avenues of support available to them. Results from the national GP patient survey for the practice were comparable to local and national averages for its satisfaction scores on consultations with doctors and nurses.

Care planning templates were available for staff to use during consultation. Information for patients about services was available and easy to understand. Patients we spoke with during our inspection said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. We saw staff treated patients with kindness, respect and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated requires improvement for providing responsive services. The practice did not have a patient participation group (PPG). There was also no advertisement of the group available to patients. There was no system in place for recording verbal complaints.

It reviewed the needs of its local population and engaged with Sheffield Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was participating in the Prime Ministers' Challenge to reduce

Summary of findings

admissions to secondary care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a complaints system for written complaints and evidence showed the practice responded quickly to issues raised and learning from complaints was shared with staff. Urgent appointments were available for patients the same day as requested but not necessarily with a GP of their choice.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.The practice acted on feedback from patients through complaints, NHS Choices website, GP national survey and the Friends and Family test and had focused on improving the patient experience of the services provided. The practice had not developed a patient participation group (PPG). They told us they were looking to establish a virtual PPG.

The practice had a vision to provide high quality, accessible and responsive care to patients. Our discussions with staff indicated the vision and values were embedded within the culture of the practice and patient safety was a priority. The practice manager encouraged a culture of an open door policy. Staff told us they were approachable and supportive. However, there were no formal processes for appraisals for all staff.

Staff generally understood their roles and responsibilities. However; we found during our discussions with staff there was some confusion at times as to roles and responsibilities.

We found the management of the practice was unorganised. The practice had limited formal governance arrangements and they were not consistently adhering to its clinical governance policy. For example, audits were not used routinely to monitor the quality of the service and practice. Fire risk assessments were not completed annually and staff training in this area had not been provided. There was no system in place for recording verbal complaints. The practice did not have an effective system for reporting and recording significant events.

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

Nationally reported data showed that outcomes for patients were similar to others in the local CCG area for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people in its population. Longer appointments, home visits and rapid access were available for those patients with enhanced needs. The practice worked closely with other health and social care professionals, such as the district nursing team and community matron, to ensure housebound patients received the care they needed.

People with long term conditions

Inadequate

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

Nursing staff had lead roles 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. All patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named clinician worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

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

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 accident and emergency (A&E) attendances. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice told us all young children were prioritised and the under-fives were seen on the same day as requested. Patients we spoke with during our inspection told us children and young

Summary of findings

people were treated in an age-appropriate way and were recognised as individuals. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Data showed immunisation uptake rates were higher for the locality.

Working age people (including those recently retired and students)

Inadequate

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

The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible. The practice provided extended opening hours. For example, the practice had extended hours on Thursday mornings from 6.45am to 8.00am. The practice also offered online services, telephone triage/consultations and a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Inadequate

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

The practice had a system to alert staff of patients living in vulnerable circumstances, including those who had a learning disability and they carried out annual health checks for people with a learning disability. Longer appointments were available for patients as needed.

We reviewed staff training records. Staff had undertaken child protection training in 2007. There was no evidence that staff had completed safeguarding adults training. However, staff knew how to recognise signs of abuse in adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice worked with multidisciplinary teams in the case management of this population group. It provided information on how to access various support groups and voluntary organisations.

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People experiencing poor mental health (including people with dementia)

Inadequate 

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

All patients had a named GP. Annual health checks were offered for these patients and data showed 100% had received one in the last twelve months. The practice actively screened patients for dementia and maintained a register of those diagnosed. It carried out advance care planning for these patients. Training had not been provided for staff relevant to consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example the local mental health team. It provided readily available on how to access various support groups and voluntary organisations, such as Age UK and the domestic abuse charities. The practice also hosted Improving Access to Psychological Therapies programme (IAPT) to support patient's needs.

Summary of findings

What people who use the service say

Results from the NHS England GP patient survey published July 2015, showed the practice was performing in line with local and national averages. There were 88 responses which is a response rate of 27% of those returned. Some of the responses were rated higher than other practices located within Sheffield Clinical Commissioning Group (CCG) and nationally:

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 76%.
- 72% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.
- 81% patients said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 74%.
- 75% patients described their experience of making an appointment as good compared to the CCG average of 69% and national average of 74%.

The following responses were comparable or below average:

- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 80% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 86% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 83% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.

As part of the inspection process we asked for CQC comment cards to be completed by patients. We received 42 comment cards which were predominantly positive with a low percentage which were negative. Many comment cards citied patients received excellent and efficient care and staff went out of their way to meet their needs. We received many positive comments about the staff, in particular the reception team. Common themes were staff were wonderful, amazing and they do their best. All staff were helpful, professional, sympathetic, caring and friendly. They also felt listened to and treated with dignity and respect.

During the inspection we spoke with four patients. We received mixed views about the care and treatment they received. Positive themes were patients were treated with dignity and respect, had confidence in the in staff and they were caring and supportive. They also said it was easy to get an appointment and at a time suit them. We received a couple of negative comments. One patient told us they felt they did not have enough time during the appointment, the GP did not listen and they were not supported during bereavement.

Areas for improvement

Action the service MUST take to improve

- Ensure there are formal governance arrangements.
- Ensure there are systems and processes in place to assess, monitor and mitigate risks to patients. Incidents and significant events are recorded and reported to the appropriate authorities. Fire risk assessment are completed annually. Fire drills are carried out. There is an ongoing programme of clinical audits to monitor quality and systems and identify where action should be taken. There is a system in place for recording verbal complaints.
- Ensure policies have implementation or review dates.
- Ensure there is a system to share information about new clinical guidelines produced by the National Institute for Health and Care Excellence (NICE).
- Ensure there is a process to ensure the safe storage of vaccines are applied consistently and records are adequately maintained. Appropriate action is taken to mitigate risk when vaccines are exposed to temperatures above recommended levels.
- Ensure there is oxygen for dealing with emergencies
- Ensure there are systems and processes for infection prevention and control (IPC).

Summary of findings

- Ensure staff receive training or regular updates relevant to their role such as, health and safety, fire safety, consent, information governance, safeguarding vulnerable adults and children and infection prevention and control.
- Ensure Disclosure and barring checks (DBS) are undertaken for health care assistants, Salaried GP and non clinical staff who act as chaperones.

Action the service SHOULD take to improve

- Ensure staff receive annual appraisals.
- Ensure there is access for patients with mobility difficulties and/or wheelchair users.
- Ensure clinical staff receive supervision.
- Ensure there is written information available for carers so they understood the various avenues of support available to them.
- Ensure there is a Patient Participation Group.

Barnsley Road 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 GP specialist advisor and a practice manager advisor.

Background to Barnsley Road Surgery

Barnsley Road Surgery is located in Sheffield. The practice is based in two storey converted house and an annex. There are 2738 registered patients at the practice. Access for patients with a disability is limited to the ground floor and there are shallow steps to the entrance. The practice has a comparable national average population of patients aged 40 to 75 year olds.

The practice provides Primary Medical Services (PMS) under a contract with NHS England. It also offers a range of enhanced services such as extended hours, remote care

monitoring, minor surgery, facilitating timely diagnosis and support for people with dementia, learning disabilities and childhood vaccination and immunisations.

Barnsley Road Surgery has one male GP and one female salaried GP. There is one female nurse and two healthcare assistants. These are supported by a practice manager and an experienced team of reception/administration staff.

The practice is open between 9.00am to 5.45pm Monday to Friday, with the exception on Thursday when the practice is closed at 12.30pm. Appointment times are Monday to Friday 9.00am to 5.30pm, with the exception on Thursday when the last appointment is 11.30. Extended hours are Thursday 6.45am to 11.30am. When the practice is closed, out-of-hours services are provided by Sheffield GP Collaborative.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting the practice we reviewed information we hold about the practice and asked other organisations and key stakeholders, such as NHS England and Sheffield Clinical Commissioning Group (CCG), to share what they knew about the practice. We reviewed policies, procedures and other relevant information the practice manager provided before the inspection day. We also reviewed the latest data from the Quality and Outcomes Framework (QOF) and national GP patient survey.

Detailed findings

We carried out an announced inspection on the 13 October 2015. During our visit we spoke with two GPs, a practice nurse, a health care assistant, the practice manager and three receptionists. We also spoke with four patients. We reviewed 42 CQC comment card where a patient had shared their views and experiences of the practice. We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We also reviewed records relating to the management of the practice and patient care.

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)

Inadequate

Are services safe?

Our findings

Safe track record and learning

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 also a recording form available on the practice's computer system. Incidents and significant events were generally recorded. However, we found incidents had not been recorded. For example, a break in the cold chain.

Safety was monitored using information from a range of sources, including National Patient Safety Alerting System (NPSAS) and National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a two week referral was missed. The practice now sends them off immediately and get a receipt and also ask the patient to call in two weeks if they have not heard from the hospital.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep people safe:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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 lead member of staff for safeguarding. However, there was a lack of clarity about who was the lead role in safeguarding. The GP partner told us they were the lead member of staff for safeguarding adults and children. We were also told that the GP partner, nurse and practice manager were the safeguarding lead. Staff we spoke with told us the lead person for all safeguarding issues was the practice manager. The GP attended safeguarding meetings when possible. The GP had not completed training in safeguarding adults and children. Staff demonstrated they understood their responsibilities and told us they would report safeguarding concerns to the practice manager.
- The training records provided to us prior to the inspection showed two health care assistants, three reception staff, practice nurse and the practice manager had completed training in safeguarding children in 2007. The records did not indicate what level of training was provided. There was no evidence in the records provided to us that the nurse, healthcare assistant and non clinical staff had completed training in safeguarding adults.
- A notice was displayed in the waiting room and consultation rooms advising patients a chaperone was available if required. One member of staff who acted as a chaperone had not received chaperone training. Non clinical staff and a healthcare assistant acted as chaperones. They did not have a Disclosure and Barring Service (DBS) check. These 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 made the decision not to carry out a DBS check for the non clinical staff, and could not provide a clear rationale as to why.
- There were two recruitment documents in place. One for the recruitment of GPs and one for the recruitment of non clinical staff. These policies were basic. These did not include obtaining satisfactory evidence that the person they were employing was of good character or obtaining satisfactory evidence of the persons conduct in previous employment. Neither of the policies were dated to evidence review to reflect current practice.
- There was a lack of systems and processes to assess monitor and mitigate risks to patients and others with respect to health and safety matters.
- There was a health and safety policy available with a poster in the waiting room. All electrical equipment was checked to ensure the equipment was safe to use and the majority of clinical equipment was checked to ensure it was working properly.
- There was evidence that fire equipment such as the fire alarm and smoke detectors had been routinely serviced. The evacuation routes were displayed. However, there were a number of actions required in order to ensure patients and staff would be protected in the event of a fire. Annual fire risk assessments were not undertaken.

We saw a fire risk assessment had been completed in November 2012. However, actions taken did not align with our findings on the day of inspection. For example, fire drills had not been undertaken and evacuation plans had not been rehearsed regarding assisting patients and visitors to evacuate the premises. Staff training records indicated staff had not received fire safety training. We referred our concerns to the South Yorkshire Fire and Rescue service following the inspection.

- There was a lack of systems and processes in place for infection prevention and control (IPC). An IPC audit had been completed in April 2015. The practice manager told us they were working through the recommendations. We saw from the audit record a number of areas had been identified as requiring improvement. We saw some action had been completed to address the shortfalls. For example, there was a cleaning schedule in place. The audit stated that all staff had received mandatory training in IPC. This did not align with our findings. We reviewed the staff training records and there was no evidence staff had received IPC training.
- An external cleaning company was used to clean the practice. The practice manager told us the cleaning company conducted cleaning audits and we saw records and certificates to demonstrate this. The consulting rooms in the practice and patient areas were visibly clean.
- The practice had carried out a Legionella (legionella is a bacterium which can contaminate water systems) risk assessment in August 2014 and this was due for re assessment. The practice manager told us this would be undertaken in November 2015.
- The practice nurse and practice manager were the designated infection prevention and control (IPC) clinical lead, who kept up to date with best practice. There was an IPC protocol in place.
- There were some arrangements for managing medicines, including emergency drugs and vaccinations. However, we found areas that required improvement. Vaccines were held in two dedicated refrigerators. We saw there were some processes to monitor the fridge temperature.
- We checked the record sheets for the vaccination refrigerator from April 2015 to October 2015. We saw there were consistent and thematic gaps in the records for this period. The majority of the gaps where the temperature had not been recorded were Wednesday, Thursday and Fridays. The minimum and maximum temperatures were not always recorded.
- We checked the record sheets for the second refrigerator from July to October 2015. There were no records for seven days in July. In September and October 2015 these records showed the maximum temperature had increased above the recommended eight degrees centigrade. There was no record of actions taken to ensure the effectiveness of the vaccines had not been compromised. The nurse had recorded in the July 2015 log that the lack of monitoring would be discussed at the staff meeting. We saw in minutes of the practice meeting September 2015 the practice nurse had identified fridge temperatures were not being completed and suggested a rota. The practice manager also told us they were aware of the monitoring issues and introduced a rota. Our findings indicated that a rota system had not been effectively implemented and responsibilities for these checks were unclear. We referred our concerns to NHS England following our inspection.
- We found the cold chain policy and procedures had not been regularly reviewed and had not been implemented. The policy stated the practice nurse and healthcare assistants were responsible for checking the vaccination refrigerator temperatures daily. The practice was not adhering to its policy.
- There was a repeat prescribing system in place. All medication reviews were six monthly and were undertaken by the GP. Prescription pads and blank prescriptions were securely stored and there were systems in place to monitor their use. We checked the doctor's bag and found glucometer strips were two years out of date.
- The practice had a recruitment policy and procedure. The policy did not include that all staff should have a DBS check and there was evidence the policy was not always being followed. The seven files we viewed showed some recruitment checks had been undertaken prior to employment. For example, evidence of references, identification, employment history and registration with the relevant professional body was available. We found DBS checks had been completed for the practice nurse. Two healthcare assistants, a salaried GP and the reception staff had not received a DBS check.

Inadequate

Are services safe?

- The GP partner told us the practice had a number of very challenging circumstances to manage. They told us this was due to a number of factors such as the design of the current building, being in one of the most deprived areas nationally and long term staff sickness. The GP told us they always try and do their best for patients to deliver a good service. The GP partner was aware of future challenges and had plans in place to manage these. For example, one of the GP partners had retired due to ill health. The practice had employed a salaried GP who was looking to become a new partner in November 2015. This would increase their clinical sessions according to need.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff told us they tried to provide cover for leave internally first. They said they had used locums in the last 12 months and locum checks would include General Medical Council (GMC) registration, indemnity cover and DBS checks. There was no evidence that DBS checks had been undertaken.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training in 2012. There were emergency medicines available in the treatment room. The practice had a defibrillator but it was obsolete and there were no plans to replace it. The practice did not have oxygen to deal with emergencies. Oxygen is considered essential in dealing with certain medical emergencies (such as acute exacerbation of asthma and other causes of hypoxaemia). Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. There was also a first aid kit and accident book available.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The practice did not have systems in place to ensure all clinical staff had access to up-to-date guidelines from the National Institute for Health and Care Excellence (NICE), the local Clinical Commissioning Group (CCG) and local disease management pathways. Therefore, assessments and treatments were not delivered in line with these guidelines and pathways to support delivery of care to meet the needs of patients. The GP partner told us they received a newsletter from the CCG with relevant guidance on a regular basis to the practice.

Training had not been provided for staff relevant to consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However, staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. Patients' consent to care and treatment was sought in line with these. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome. When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency. This is used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Protecting and improving patient health

The practice's uptake for the cervical screening programme was 97%, which was higher than the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation uptake rates for the vaccinations offered were higher to both the local CCG and national averages. For example, uptake rates for children aged 24 months and under ranged from 89% to 100% and for five year olds they ranged from 92% to 97%.

The seasonal flu vaccination uptake rate for patients aged 65 and over was 74%. Uptake for those patients who were in a defined clinical risk group was 64%. These were also higher to both the local CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40 to 74. Where abnormalities or risk factors were identified, appropriate follow-up on the outcomes were undertaken.

The practice identified patients who were in need of additional support and signposted them to the relevant service. For example, smoking cessation advice, support for alcohol abuse or help with weight management.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to clinical staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care plans, medical records and test results. Information such as NHS patient information leaflets were also available.

Staff worked with other health and social care services to understand the complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, such as when they were referred or after a hospital discharge. The GP told us that two week referrals were done on a template and sent the same day. They told us one two week wait referral was not sent and they have put a system in place to prevent this happening again. We saw evidence multidisciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a process intended to improve the quality of general practice and reward good practice. Information collected for the QOF and performance against national screening programmes was used to monitor outcomes for patients. Data from 2013/14 showed:

- The practice had achieved 99% of the total number of points available and was not an outlier for any QOF (or other national) clinical targets and had an exception rate of 4.5%

Inadequate

Are services effective?

(for example, treatment is effective)

- Performance for diabetes related indicators was comparable to the CCG and national average.
- The percentage of patients with hypertension having regular blood pressure tests was comparable than the CCG and national average.
- Performance for mental health related and hypertension indicators were higher than the CCG and national average.
- The dementia diagnosis rate was higher than the CCG and national average

Clinical audits were carried out, however not all relevant staff were involved to improve care, treatment and patient outcomes. Audits were not used routinely to monitor the quality of the service and practice. We saw the practice had two completed clinical audits. For example, hydroxyzine drug interactions. The actions were planned with changes to practise. There was no evidence these occurred and no second audit cycle to assess impact. We saw several audits had been done by an external company paid by a pharmaceutical company. The report included recommended actions. There was no evidence that actions had been taken.

Effective staffing

The nurse and healthcare assistants had completed role specific training such as childhood immunisation, asthma and diabetes.

We found areas that required improvement: Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence reviewed showed some areas for improvement:

- The practice had an induction programme for newly appointed staff which included policies and procedures.
- Records showed staff had not received training that included health and safety, safeguarding, fire safety, infection prevention and control and information governance awareness.
- The practice manager told us they had an open door policy to support staff and they were could informally identify any training they wished to attend. Staff told us that they felt supported and had informal meetings with their manager and discuss training needs. Staff told us they did not have protected learning time to undertake further training. Individual training needs had not formally been identified through the use of appraisals and reviews of practice development needs.
- There were no systems in place for nursing staff to receive clinical supervision or for competency to be assessed and monitored. However, the practice nurse engaged with the CCG and locality practice nurse forums for support.
- Some staff we spoke with appeared demotivated and this may be a reflection of their recent staffing problems.
- All GPs were up to date with their revalidation and appraisals.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous, helpful and showed empathy to patients both attending at the reception desk and those spoken with on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during patient consultations and conversations taking place in these rooms could not be overheard.

On the day of our inspection we spoke with four patients. They all told us they felt the practice offered an excellent service and staff were helpful, considerate, caring and treated them with dignity and respect. Reception staff were aware they could offer a private room when patients wanted to discuss sensitive issues or appeared distressed. Ninety five percent of respondents to the national GP patient survey found receptionists at the practice helpful, compared with a CCG average of 85% and a national average of 87%. This aligned with our findings.

The practice's computer system alerted clinicians if a patient was also a carer. There was no written information available for carers to ensure they understood the various avenues of support available to them.

The practice manager told us staff knew patients well and had a good relationship with them. Therefore, if families had experienced bereavement, a member of the reception team would visit the family to offer support. The GP does not routinely contact them. Patients told us they were generally supported during bereavement either through the Improving Access to Psychological Therapies (IAPT) service or by the GP. One patient told us that they felt they were not supported by the practice during bereavement.

Results from the national GP patient survey showed the practice was below or comparable to local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 80% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87%.
- 80% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 86% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 83% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.

We reviewed 42 CQC comment cards patients had completed prior to the inspection and spoke with four patients. The majority of patients were positive about their experience of the service. A number of comments described the GPs and nurse as attentive, helpful, caring, supportive, amazing, excellent and they felt listened to. One patient told us that the staff were like family and very supportive. Two patients felt they were not listened to.

Care planning and involvement in decisions about care and treatment

Data from the July 2015 national GP patient survey showed patients responded satisfactorily to questions about their involvement in planning and making decisions about their care and treatment. These were not in line with local and national averages. For example:

- 68% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 73% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%

Patients we spoke with on the day of our inspection told us health issues and treatments were discussed with them and they felt listened to. The majority of patients told us they felt involved in the decisions about their care and are able to ask questions about their treatment and care. They told us staff go that extra mile to help them.

Staff told us translation services were available for patients who did not have English as a first language. Notices in the patient waiting areas provided information on how to access a number of support groups and organisations,

Requires improvement

Are services caring?

such as Age UK and domestic abuse. However, there was no information available for carers to ensure they understood the various avenues of support available to them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area. For example, they were participating in the Prime Ministers' Challenge Fund (this involves providing four extra appointments per week at the surgery and patients can also access appointments at Sheffield satellite practices). As part of this scheme, the practice offers patients an appointment slot at a neighbouring practice on Thursday afternoons. At the time of our inspection there was no data available to support the intended outcomes.

The practice had not been able to develop a patient participation group (PPG). There was no advertisement of the group available to patients. The practice manager told us they had tried to establish one, however there was no interest. They told us they were going to look at developing a virtual PRG to try to push this forward. The practice acted on feedback from patients through complaints, NHS Choices website, the Friends and Family test and media. For example a newspaper article stated that a patient had to wait six weeks to get an appointment. The practice manager displayed the article in the waiting room asking patients to discuss any concern with them. We were told patients provided positive feedback.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example:

- The practice offered extended appointments on Thursdays 6.45am to 8.00am for working patients who could not attend during normal opening hours.
- There were longer appointments available upon request for people with a learning disability.
- Home visits were available for patients who could not physically access the practice.
- Urgent access appointments were available for children and those with serious medical conditions.
- Patients could book appointments online.
- There were disabled facilities, hearing loop and translation services available.

Access to the service

The practice is open between 9.00am to 5.45pm Monday to Friday, with the exception on Thursday when the practice is closed at 12.30pm to 1.30pm. Appointment times are Monday to Friday 9.00am to 5.30pm, with the exception on Thursday when the last appointment is 11.30. Extended hours are Thursday 6.45am to 11.30am. Appointments could be pre-booked up to six weeks in advance and urgent appointments were available.

Results from the national GP patient survey showed patients' satisfaction with how they could access care and treatment was above or comparable to local and national averages. For example:

- 81% patients said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 74%.
- 75% patients described their experience of making an appointment as good compared to the CCG average of 69% and national average of 74%.
- 72% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.

CQC comment cards received were predominantly positive and aligned with these findings. One person we spoke with told us the appointment times were not flexible for the working population.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The complaints policy outlined the timescale the complaint should be acknowledged by and where to signpost the patient if they were unhappy with the outcome of their complaint. Information how to make a complaint was available in complaints and compliments leaflet.

The practice kept complaints register for all written complaints. There had been four complaints over the last 12 months. We found they had all been satisfactorily dealt with, identifying actions, the outcome and any learning. There was no system in place for recording verbal complaints.

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 practice had a vision to provide high quality, accessible and responsive care to patients. Our discussions with staff indicated the vision and values were embedded within the culture of the practice and patient safety was a priority. The practice manager encouraged a culture of an open door policy. Staff told us they were approachable and supportive. They also spoke positively about the practice and how they worked collaboratively as a team. We observed a team work ethos during our observations.

Governance arrangements

The practice had an overarching governance policy. This outlined the structures and procedures in place which incorporated: patient involvement, audit, evidence based treatment, staff management, information and its use, risk control, continuing professional development, patient experience and strategic capacity. We found the management of the practice was disorganised and unorganised. The practice was not consistently adhering to its own policies. For example:

- Staff generally understood their roles and responsibilities; however we found during our discussions with staff, including GPs, healthcare assistants and nurse there was some confusion at times as to roles and responsibilities.
- Clinical audits were not used routinely to monitor the quality of the service and practice, there was no evidence of two cycle audits.
- Fire safety risk assessments had not been completed annually.
- We found there were information governance, clinical governance and recruitment policies. There were no dates of implementation or review dates. The management of medicines protocol was dated 2008 and had not been reviewed.
- There were two recruitment documents in place. One for the recruitment of GPs and one for the recruitment of non clinical staff. These policies were basic. These did not include obtaining satisfactory evidence that the person they were employing was of good character or obtaining satisfactory evidence of the persons conduct in previous employment. Neither of the policies were dated to evidence review to reflect current practice.
- The practice did not have systems in place to ensure all clinical staff had access to up-to-date guidelines from the National Institute for Health and Care Excellence (NICE), the local Clinical Commissioning Group (CCG) and local disease management pathways.
- There was no system in place for recording verbal complaints.
- The practice did not have an effective system for reporting and recording significant events.
- The practice did not have a patient participation group.
- Staff were not supported through annual appraisals.

We saw one area where they were following their clinical governance policy. For example:

- The practice held regular staff meetings where governance issues were discussed. We looked at minutes from these meetings and found performance, quality and risks had been discussed.

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 **Staff training provision and support was not adequate because:** • Staff had not received training or regular updates in areas such as health and safety, fire safety, safeguarding vulnerable adults and children, consent, infection control, chaperone or information governance. • Clinical supervision was not provided for nurses. • Staff did not receive annual appraisals. Regulation 18(1) (2)(a)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Systems and processes to assess, monitor and mitigate risks to patients and others health and safety were not adequate because:** • Staff had not received training or regular updates in areas such as health and safety, fire risk safety, consent, safeguarding vulnerable adults and children, information governance, chaperone and infection control. • Incidents and significant events were not consistently reported. • A fire risk assessment had not been completed annually. Fire drills had not been carried out. • The practice did not have oxygen for dealing with emergencies. Regulation 12(1)(2)(a)(b)(c)(d) **Processes to ensure the safe storage of vaccines were applied inconsistently and records were not adequately maintained. Appropriate action had not been taken to mitigate risk when vaccines had been exposed to temperatures above recommended levels.** Regulation 12(1)(2)(g) **Systems and processes for infection prevention and control (IPC) were not adequate because:** • Staff training had not been provided. Regulation 12(1)(2)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Surgical procedures Treatment of disease, disorder or injury	Governance procedures were not adequate because: • Systems to assess monitor and improve the quality and safety of the services provided were not adequate. 17(1) (2)(a)(f) Systems to assess monitor and mitigate risks relating to health, safety and welfare of patients were not adequate. 17(1) (2)(b)(f)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found the practice had not employed fit and proper persons because: • Not all staff had received a Disclosure and Barring (DBS) check to demonstrate that they are of good character. 19 (1) (a) The provider did not ensure that all staff had the qualifications, skills and experience which are necessary for the work to be performed - By ensuring staff received updates and training. 19(1)(b), 2(a)