Dr Sunil Srivastava

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?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Sunil Srivastava (Richmond Medical Centre) on 14 October 2014. During the inspection we gathered information from a variety of sources. We spoke with patients, interviewed staff at all levels and checked that the right systems and processes were in place.

Overall the practice is rated as inadequate and improvements must be made. This is because we found it inadequate for providing safe, effective and responsive services and being well led. It was also inadequate for providing services for all the population groups:

- Older people
- People with long term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances make them vulnerable
- People experiencing poor mental health (including people with dementia)

Improvements were also required for providing caring services.

Our key findings were as follows:

- Risks to some patients who used services were identified and assessed but systems and processes to address these issues were not implemented in a way to identify risks and keep them safe.
- Appropriate recruitment checks on staff had not been undertaken prior to their employment, for example criminal records checks (Disclosure and Barring Service - DBS).
- Urgent appointments were usually available on the day they were requested. However, we found that the routine appointment system was not working, as patients experienced difficulty getting through on the telephone and were often waiting long periods of time when attending for their appointment.
- There was no evidence of completed audit cycles.

Summary of findings

- The practice had no lead for infection control and there had been no recent infection control audits undertaken. Actions identified by an independent contractor had not been addressed.
- Most patients were positive about their interactions with staff and said they were treated with compassion.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements are in place that includes all necessary employment checks for all staff.
- Ensure review systems for assessing and monitoring the quality of the service provision and take steps to ensure risks are managed appropriately.
- Ensure there are formal governance arrangements in place and staff are aware of how to implement these to ensure the practice functions in a safe and effective manner.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which is reflective of the requirements of the practice.
- Ensure that the practice understands the requirements with respect to consent and capacity and ensure they always act in accordance with the consent of patients.
- Ensure the practice has in place a sufficient number of administrative staff in order to facilitate the smooth running of the practice and to safeguard the health, safety and welfare of patients.
- Take action to address infection prevention and control to ensure the practice complies with the 'Code of Practice for health and social care on the prevention and control of infection and related guidance'.
- Ensure patients' dignity and privacy is maintained in relation to their care and treatment.
- Ensure patients' medical records and personal details are held securely and remain confidential.

The practice will have six months to make the improvements required by this report. We will carry out a further inspection at the end of that time.

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 safe.

Staff were clear about the needs for reporting incidents, near misses and concerns. However, no record was available of a significant event we were told about. There was no evidence to show significant events were analysed over time. Risks to some patients who used services were identified and assessed but systems and processes to address these issues were not implemented in a way to identify risks and keep them safe. The practice did not have a risk log to record identified risks. Risks associated with service and staffing changes (both planned and unplanned) were not recorded. The practice did not have in place a sufficient number of administrative staff to safeguard the health, safety and welfare of patients. The practice did not have systems in place to manage the risks to patients, visitors and staff when visiting or in the practice.

While the practice had a range of policies in place such as health and safety and fire safety, the practice was not implementing these. The practice had also not followed its own recruitment policy and had not recruited staff safely. Medication was not securely stored and equipment used for procedures was not within its sterile date. Safeguarding training was not appropriately managed.

Are services effective?

Inadequate

The practice is rated as inadequate for effective.

Knowledge of and reference to National Guidelines aimed at delivering good patient care was inconsistent. Some data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. Patient outcomes were hard to identify as little or no reference was made to completed audit cycles to demonstrate improvement. There was evidence the practice was carrying out local peer review but not comparing its performance to others - either locally or nationally. The practice did not evaluate the service or plan and review the service to improve performance. Multidisciplinary working was reportedly taking place, although there was limited evidence recorded. The practice could not identify that all staff were appraised and had personal development plans.

Are services caring?

Requires improvement

The practice is rated as requires improvement for caring.

Summary of findings

The majority of comments received from CQC comment cards and patients on the day of the inspection showed patients were listened to and supported. However, data from the national patient survey showed the practice was rated lower than others in these areas. We observed that patient confidentiality was not always maintained by the GP and by reception staff within the waiting area. This was also reflected in the national patient survey data.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for responsive.

The practice had implemented suggestions for improvement to the way it delivered its services as a result of feedback from the patient participation group (PPG) and the patient survey. There was some engagement with the Clinical Commissioning Group (CCG) in order to improve services. People needing urgent attention were usually seen on the same day. However, we found there was no review of the impact of the changes being made and we saw that some changes were not always working. We also found that the routine appointment system was not working, as patients experienced difficulty getting through on the telephone and were often waiting long periods of time when attending for their appointment. This was also reflected in the national patient survey data which showed the practice was significantly below the CCG and national average. There was also no accessible information for patients regarding complaints and furthermore we were not able to determine whether there had been any complaints about the practice.

Are services well-led?

Inadequate

The practice is rated inadequate for well-led.

While clinical staff were clear about their roles, there was no clarity about the governance and quality monitoring arrangements. The practice did not have a clear vision or strategy about how it would deal with current and future changes and demand. There were no systems in place to monitor the quality of services or identify risks associated with the practice. We saw that while the practice had a number of policies and procedures in place, such as those concerned with safeguarding and medicine management, all of those we saw had not been reviewed within the past 12 months. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people.

Longer appointments and home visits were available for older people. As this was a single handed GP practice all patients over the age of 75 years had a named GP. Patients over the age of 75 years were identified as needing extra support and had been offered a review at the practice.

Older patients were offered a chaperone service at the practice. However staff offering this service were not trained and did not have a police check (Disclosure and Barring Service DBS). There was no evidence that the leadership of the practice had started to engage with this patient group in order to look at further options to improve services for them.

People with long term conditions

Inadequate

The practice is rated as inadequate for the population group of people with long term conditions.

When needed, longer appointments or home visits were available. We were told patients were reviewed every three months. The practice had carried out screening for chronic obstructive pulmonary disease (COPD) patients. However, there was no evidence of a structured review of these patients. Data from the NHS England primary care information showed this practice had two level one triggers for this patient group. For example, the high level of emergency admissions for patients with long term conditions. There was no evidence available to show the practice had taken action to improve performance in these areas.

Families, children and young people

Inadequate

The practice is rated as inadequate for the population group of families, children and young people.

Patients had access to a weekly baby clinic and midwife and a full range of immunisations, although data supporting the extent of performance in this area was not available. Appointments were available outside of school hours and we were told that emergency appointments for children were prioritised.

However, systems were not in place for identifying and following up children living in disadvantaged circumstances and who may be at risk. For example, with respect to children and young people who had a high number of A&E attendances or those children who were

Summary of findings

identified by the local authority as having safeguarding concerns. There was no evidence available to show the practice had systems in place to monitor or alert clinical staff about these concerns. The practice's performance was also significantly below that of other practices with respect to the uptake of cervical smears. While the practice was aware of this and had done some promotion of this service, it had not put in place any means of following up patients who had not attended their appointment.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the working-age people (including those recently retired and students).

The uptake of health checks for this age range was good. The practice patient age profile was mainly those of working age but the services available did not reflect the needs of this group. The practice offered some extended opening hours Monday to Friday. However, there was only telephone access for appointments and there was no on-line appointment system or on-line repeat prescription service available. Health promotion advice was offered but there was limited accessible health promotion material available at the practice.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the population group of people whose circumstances may make them vulnerable.

While the practice held a register of patients with a learning disability there was no information about other people who may be vulnerable; such as homeless people or travellers. Arrangements were not in place to ensure patients with a learning disability had an annual health check. While staff knew how to recognise signs of abuse in vulnerable adults and children, not all staff were adequately trained in this regard. Systems were not in place for recording concerns raised by the Local Authority safeguarding team.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the population group of people experiencing poor mental health (including people with dementia).

The practice had signposted patients experiencing poor mental health to various support services including the local community mental health team. The practice offered patients extended appointment times. However, there was no evidence to show that patients in this population group had care plans. No systems were

Summary of findings

in place to follow up on patients who had attended accident and emergency where they may have been experiencing poor mental health. There was no evidence to show the practice had worked with multi-disciplinary teams in the case management of people experiencing poor mental health. There was also no evidence that the practice carried out advanced care planning for patients with dementia. The NHS England data also showed that the practice performed poorly (and had a level one trigger) with respect to carrying out physical health checks for patients with severe mental illness (SMI).

Summary of findings

What people who use the service say

We received 27 CQC comment cards and spoke with three patients on the day of our inspection. We spoke with patients from different age groups.

The majority of patients we spoke with were complimentary about the care they received. They told us staff were very good and they were treated with dignity and respect. Patients said they felt supported and listened too by the GP and that their needs were met. Four CQC comment cards showed that getting an appointment was not always easy and appointment waiting times were often lengthy. Two patients raised concern that they could hear confidential discussions between reception staff and patients in the waiting area.

A review of the NHS England primary care data showed the practice was performing below the England average in relation to the level of patient satisfaction in relation to access to the practice. The national GP survey results for 2014 completed by 22% of patients showed the practice performed below the weighted CCG (regional) and national average in most areas. For example:

- 46% of respondents usually waited 15 minutes or less after their appointment time to be seen - CCG (regional) average: 72%
- 61% of respondents would recommend this surgery to someone new to the area - CCG (regional) average: 77%
- 70% of respondents were able to get an appointment to see or speak to someone the last time they tried - CCG (regional) average: 84%

These results were consistent with our findings on the day of the inspection.

Areas for improvement

Action the service MUST take to improve

Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The practice did not operate effective recruitment procedures which ensured staff were fit to undertake their role.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The practice did not have:

- Effective systems in place to assess the risk of and to prevent, detect and control the spread of a health care associated infections
- Maintain appropriate standards of cleanliness and hygiene

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The practice did not have suitable arrangements in place for assessing and monitoring the quality of service provision. These included:

- The practice did not have systems in place to review the effectiveness of learning actions.
- The practice did not have systems in place to manage and monitor risks to patients, staff and visitors safety when visiting or working in the practice
- Clinical audit cycles were not used to monitor the quality of the service and deliver improvement.
- Audits in areas such as medication and infection control were not used to monitor safety.
- The practice did not have systems to show they used information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients.
- Not all staff were appraised.
- Clear and planned governance structures were not in place.
- No risk management processes or strategies were used to monitor and improve the quality of service provided.
- Lack of systems for monitoring staff training and recording staff induction.
- Lack of systems for identifying vulnerable patients on patients electronic records.

Summary of findings

Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The practice did not have in place a sufficient number of administrative staff to safeguard the health, safety and welfare of patients.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The practice demonstrated a fundamental lack of understanding of both "capacity" issues as outlined in the Mental Capacity Act and "safeguarding" as outlined in the local procedures and regulations. The practice did not always act in accordance with the consent of patients.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The practice did not ensure that patients' dignity and privacy was maintained in relation to their care and treatment.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The practice did not ensure patients' medical records and personal details were held securely and remained confidential.

Action the service SHOULD take to improve

Health promotion, complaints and information about chaperoning was not available in the practice waiting area.

Dr Sunil Srivastava

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 and another CQC inspector.

Background to Dr Sunil Srivastava

Richmond Medical Centre, 15 Upper Accommodation Road, Leeds. West Yorkshire, LS9 8RZ is situated in the ward of Burmantofts and Richmond Hill in Leeds. The registered patient list size of the practice is 2,167 of which 1205 are male and 962 are female. Deprivation affecting children and older people is higher than the local and national average for deprivation. There is one full time GP and one part time GP partner, one full time practice nurse, a practice manager and two part time administrator/receptionists.

The practice has a general medical services (GMS) Contract under section 84 of the National Health Service Act 2006. NHS England and the practice enter into a general medical services contract under which the practice is to provide primary medical services and other services in accordance with the provisions of the Contract.

The practice has opted out of providing out-of-hours services to their own patients. Patients use the 111 service when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting Richmond Medical Centre, we reviewed information we hold about the service and asked other organisations to share what they knew about the service. We asked the practice to provide a range of policies and procedures and other relevant information before the

Detailed findings

inspection. However these were not made available to us. We carried out an announced inspection visit on 14 October 2014. During our inspection we spoke with a range of staff including the GP, practice nurse and an administrator. We spoke with three patients who used the service. We were unable to contact members of the PPG as the practice failed to provide us with contact details when requested, both before and after the inspection. We observed how patients were being cared for and talked with carers and/or family members. We reviewed 27 CQC comment cards where patients and members of the public shared their views and experiences about the service.

Inadequate

Are services safe?

Our findings

Safe Track Record

The practice did not have effective arrangements in place to ensure the delivery of safe patient care or systems to protect the health and safety of patients, staff and visitors to the practice. There was insufficient information or documented evidence made available to demonstrate the practice had managed risk to patients.

The practice could not evidence they held regular meetings with staff to discuss issues such as significant events, safeguarding and complaints. There was no evidence available to show that significant events were analysed over time or that the effectiveness of learning actions had been reviewed. Risks to some patients who used the service were identified and assessed but systems and processes to address these issues were not implemented, such as patients with chronic obstructive airways disease (COPD).

Risks associated with service and staffing changes (both planned and unplanned) were not recorded. The practice did not have in place a sufficient number of administrative staff in order to facilitate the smooth running of the practice and to safeguard the health, safety and welfare of patients.

Learning and improvement from safety incidents

National patient safety alerts were disseminated in paper format to practice staff. The practice nurse was able to give an example of a recent medication alert and the action they had taken. While they also told us alerts were discussed within the practice, there was no evidence available to confirm this.

While the practice had a system in place for reporting significant events, incidents and accidents, it was evident that the system was not being implemented appropriately or effectively. We found records of incidents that had occurred over the past 24 months although there were no new records over the past 11 months. Furthermore, the GP informed us of a recent significant event (where a locum GP had not attended a home visit as required). This had not been recorded as a significant event and there were no records to show what learning or discussion had occurred as a result. For those events that were recorded there were notes referring to actions to be taken, but there was no evidence to show that the action had been taken or that it was subsequently reviewed.

Our concern is that the practice has not demonstrated its understanding of significant events and may not recognise them when they occur. We would expect to have seen a number of significant events recorded for a practice of this size.

Reliable safety systems and processes including safeguarding

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to report information of concern to the practice lead or other relevant agencies. A safeguarding policy and contact details were accessible to staff. The practice attended multi-disciplinary safeguarding meetings when required and records confirmed this.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. GPs are required to be trained (to Level 3) in order for them to fulfil their role as safeguarding lead. It was evident that the GP had only completed this training at the time of the inspection. The GP had not had any previous safeguarding training. We were told the practice nurse, practice manager and the reception staff had completed training in safeguarding adults and children but there were no records to confirm this.

The practice did not have systems in place to highlight patients identified by the local authority safeguarding as potentially vulnerable. While the practice had a chaperone policy, there was no information about chaperoning service displayed within the practice, and the administrative staff that provided the chaperone service had not been trained to undertake this role.

Medicines Management

There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Vaccines were

administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance. The nurse had completed up to date training to administer vaccines.

There was a system in place for the management of high risk medicines, such as warfarin, which included regular monitoring in line with national guidance. Records confirmed the procedure was being followed. We saw records to show the practice was monitoring and reporting the use of Level 3 Amber Drugs to the CCG. These are medicines such as Methotrexate and Cyclosporin. These are drugs that should be initiated by a specialist, and which require significant monitoring on an on-going basis. The records showed the practice was 100% compliant with appropriate guidelines for the monitoring of these drugs.

Blank prescription forms were handled in accordance with national guidance as these were tracked and kept securely at all times.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. Staff that generated prescriptions were clear about their role in managing changes to patients' repeat medicines. We saw appropriate action taken by staff on the day of the inspection when a repeat prescription was requested. However, we also noted that the practice did not have systems in place to follow up prescriptions that were returned to them by the pharmacy as being uncollected medicines by patients.

There were also other shortfalls with respect to the management of medicines. We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were not stored securely. Emergency and other medicines were located in treatment rooms accessed via a keypad system but they were not stored securely within these rooms. For example, emergency medicines were located on work surfaces and some medicines were found in unlocked drawers. We were told only authorised staff could enter via the keypad system. However on the day of the inspection we observed access was given to an external contractor with no regard to the medicines that were stored insecurely in the room.

Cleanliness & Infection Control

We observed the majority of areas accessible to patients to be clean and tidy. Sharps bins were available, appropriately stored and used. Bins with lids and foot pedals for the disposal of general and clinical waste were in place. Special kits to be used in the event of a spillage of blood or body fluids were available and stored appropriately. Personal protective equipment (PPE) such as gloves and aprons were available and staff were seen wearing them throughout the day. A needle stick injury policy was in place. Hand wash and safe hand washing guidance was displayed in treatment rooms. Records were in place for cleaning some pieces of equipment, such as ear syringes. Daily cleaning schedules were followed and monitored.

However, we noted that there were other areas that the practice needed to address. Areas used by staff only, such as the staff toilet and the sink area where catering facilities were located were not clean. While the practice had an infection prevention and control policy (IPC), it was not clear if there was a designated IPC lead. We saw that not all hand sanitizer dispensers in the patient waiting areas were in working order.

Some cleaning equipment was inappropriately stored in the public access ways. Plastic privacy curtains were used in treatment rooms and some of these were not clean and were torn. These were disposable curtains but it was not evident when these would be either cleaned or replaced.

There was equipment that was used for procedures such as smear tests and for minor surgery and these were disposable and would therefore reduce any risks of infection to patients. However, there was no system in place for checking that single-use items were used within the prescribed date. We found a number of items such as hypodermic needles and dressings that had passed the sterile date and these could have been used by clinical staff.

Legionella (a bacterium found in the environment which can contaminate water systems in buildings) testing was carried out in May 2014. The recommendations from this test, for example staff training and regular water testing had not been acted upon.

There had not been any recent infection control audits carried out which meant the practice had failed to identify a number of infection control issues.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Arrangements were in place

for testing and calibrating equipment. Equipment in use at the practice was tested and calibrated on the day of the inspection as part of the annual contractual arrangements. All equipment was certified as being in working order.

Medical equipment including medicines, a defibrillator, pulse oximeter and oxygen were available, in date and ready for use in the event of a medical emergency. However, there were no systems in place for checking the oxygen levels in the tank were sufficient to respond to an emergency in the future.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards to follow when recruiting clinical and non-clinical staff. The practice was not following this policy. The practice did not keep staff files. While the GP had had a police check (Disclosure and Baring Service check - DBS) as part of their registration and being on the performers' list, the other clinical and non clinical staff had not had a DBS check.

Clinical staff were responsible for ensuring their professional registrations were up to date. No other arrangements were in place for the practice to check the professional registrations with the relevant professional bodies.

We observed that the practice did not have in place a sufficient number of administrative staff to ensure the smooth running of the practice and at the same time safeguard the health and safety of patients. We observed the only phone line into the reception ringing for long periods of time with calls being abandoned and long queues of patients at the reception desk. There was only one administrator to answer calls, manage the reception desk and carry out all the administrative tasks. Patients we spoke with on the day of the inspection raised concern about the appointment waiting times and getting through to the practice via the telephone. When contacting the practice prior to the inspection we experienced similar difficulties.

Monitoring Safety & Responding to Risk

The practice did not have systems and processes in place to manage and monitor risks to patients, staff and visitors to the practice. There was no health and safety information displayed within the practice. While the practice had conducted an audit with respect to legionella, as noted earlier it had failed to carry out the actions recommended by the audit. There was no evidence of any other risk assessments in accordance with the Disability Discrimination Act 2005. Risk assessments of this type make sure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

The practice had a health and safety policy and a fire safety policy. However, the fire safety policy did not contain details of nominated fire officers or fire marshals for the practice and it was evident that the practice was not implementing its policy. For example, the policy stated fire tests and evacuations would be carried out. There was no evidence of either of these being completed. Staff had not been trained with respect to fire safety. A recent fire risk assessment (required to maintain fire safety) had not been undertaken. Neither the health and safety or the fire policy had been reviewed in the past 12 months.

The practice had failed to demonstrate that it was aware of the risks associated with the practice and the equipment in use at the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff had received training in cardio pulmonary resuscitation. Emergency medicines were available and all staff knew of their location. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Emergency equipment was available and this included access to oxygen, pulse oximeter and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment. There were no records available to confirm this equipment was regularly checked

A business continuity plan to deal with emergencies that might interrupt the smooth running of the service such as power cuts and adverse weather conditions was made available to us. However, the plan was not tailored to this practice and contained information relating to another service. The plan did not contain any emergency contact details and staff were not aware of this business continuity plan.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff told us they were familiar with current best practice guidance; accessing guidelines from the National Institute for Health and Care Excellence, journals and from local commissioners.

The practice nurse said that they led on the management of long term conditions, such as COPD and asthma. While the practice appeared to be performing well in early identification of the COPD patients, it was not clear firstly how many patients were being identified, secondly if these patients had been followed up and finally if the action plan agreed with the CCG in August 2014, had been implemented.

The practice had signed up to a bowel screening programme, an initiative led by the CCG. While the practice had submitted an action plan in September 2014, which identified actions to be completed within three months, we saw no evidence of any progress on the agreed actions.

We were provided with three studies that had been completed by the practice to demonstrate their compliance with NICE guidelines. The first related to general antibiotic prescribing during a period of May to August 2012. The results showed the practice was entirely compliant with NICE guidelines. However, the other two audits showed variable levels of compliance. The second related to antibiotic prescribing for urinary tract infections (UTI during a time period of April to June 2014). The results showed the practice was 50% compliant with Public Health England (PHE) UTI diagnostic guidelines and 77% compliant with LHP lower UTI primary care guidelines. We saw no evidence of any further audits to improve the compliance level. The third audit related to antibiotic prescribing for respiratory infections during a time period of June to August 2013. The results showed 67% of patients were prescribed antibiotics in line with NHS Leeds current primary care guidance and NICE clinical guidance. There was no further evidence of other efforts aimed to improve the level of compliance with guidance. .

Management, monitoring and improving outcomes for people

The practice nurse and practice manager were responsible for the management of the information submitted for the quality and outcomes framework (QOF), a national performance measurement tool for general practices. It was evident that the practice was not using this information and their comparative information with other practices to lever improvement despite their comparative poor performance in some areas, such as smoking cessation advice, emergency long term admissions, and identification of coronary heart disease. The practice was performing below the England mean average in eight areas of the general practice outcome standards (GPOS). These concerned:

- Smoking Cessation Advice
- Identifying CHD
- Naproxen & Ibuprofen
- Emergency LTC Admissions
- Satisfaction (quality)
- Satisfaction (overall care)
- Satisfaction (access)
- Depression Prevalence

We were advised that should the practice identify another indicator which was significantly below that of comparators, then the practice would be subject to further review and closer monitoring by NHS England.

The practice showed us eight clinical audits that had been undertaken in the last two years. None of these were completed audit cycles. In the main these were data and case study submissions for peer review and the CCG. Where the audit had led to an action we could not find any evidence of the practice taking action as a result. We were told by the CCG that the practice had signed up to the NHS England strategy 'Avoiding Unplanned Admissions / Proactive Care Programme Enhanced Services'. The practice had also signed up to a practice agreement detailing how the practice would work with their local Integrated Health and Social Care Neighbourhood Team. These are plans and agreements with local health and social care commissioners to work together for people with complex health needs. There was no evidence that the practice had acted on these agreements.

Effective staffing

Practice staffing included one full time GP and one GP who worked one evening per week, one practice nurse, a practice manager and two part time administrators. The

Inadequate

Are services effective?

(for example, treatment is effective)

practice did not have in place a sufficient number of administrative staff to ensure the smooth running of the practice and to safeguard the health and safety of patients. While the GP was up to date with their continual professional development (CPD) requirements and had been revalidated as a GP, there was no evidence to show that other staff had completed other essential training or had peer reviews and/or GP appraisals.

The GP received external peer review and appraisal and records confirmed this. The practice nurse received external peer review and we were told was appraised by the GP. There were no records available to confirm this. The practice manager was not appraised and administrative staff had not been appraised in the last 12 months. There were no induction records for the most recently recruited member of staff.

Working with colleagues and other services

Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. Staff were clear on their responsibilities for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP reviewed these and was responsible for the actioning as required. All the staff we spoke with understood their roles and felt the system in place worked well.

We were told the practice held multidisciplinary team meetings every 6 – 8 weeks to discuss the needs of complex patients on issues such as patients with end of life care needs. The meetings were attended by district nurses, community matrons and palliative care nurses. We saw one set of recent minutes which showed patients care and treatment was discussed.

An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several electronic systems to communicate with other providers. There was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. However, this system was not working effectively. We noted the CQC's quality risk profile (QRP) rated the practice as 'Much worse than expected' as only 80% of newly registered patients having had their notes summarised within 8 weeks of receipt by the practice.

For emergency patients, the practice told us they typed up a summary of a patient's record to take with them to A&E. The practice had not signed up to the electronic Summary Care Record and did not have plans to demonstrate this was being considered. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

Consent to care and treatment

Clinical staff were aware of the Mental Capacity Act 2005 and demonstrated an understanding of Gillick competency (The notion of Gillick competency helps clinicians to assess children aged under 16 about their capacity to consent to medical examination and treatment.) Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. There was a practice policy for confidentiality and documenting consent for specific interventions.

However, despite this there were a number of shortcomings with respect to consent and capacity. The practice was not able to demonstrate how patients, who had learning disabilities or those patients with dementia, had been involved and supported to make decisions through the use of care plans.

Despite the assurance given that consent was always sought, we were told about an instance where a patient who was considered to have capacity had refused treatment. The practice ignored the patient's refusal and contacted both the local authority safeguarding team and the patient's family. This was not a safeguarding matter and the safeguarding team declined to accept the case. This example demonstrated a fundamental lack of understanding of both "capacity" issues as outlined in the Mental Capacity Act and "safeguarding" as outlined in the local procedures and regulations.

We also noted that the practice was not registered with the Information Commissioners Office as a data controller for the purpose of obtaining, recording, storing and updating and sharing personal information as required by the Data Protection Act 1998.

Inadequate

Are services effective?

(for example, treatment is effective)

Health Promotion & Prevention

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw records of monitoring of the uptake of childhood immunisations that were kept by the practice nurse.

The practice policy was to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns. However, the practice only had some arrangements in place for identifying patients who needed additional support. The practice had registers of patients with certain conditions such as patients with learning disabilities, dementia and mental health issues, but was not proactively using these lists to review patients' health.

The practice's performance on the QOF was below average in a number of clinical health prevention areas. For example cervical smear uptake was 6.0 percentage points below CCG average and 6.4 percentage points below England average. The practice was aware of this. The practice promoted basic information about cervical smears on the information board in the waiting area and on the practice website. The practice did not have mechanisms in place for following up patients who did not attend for cervical smears. Other data showed the practice was performing at least 10% below the national average for flu vaccinations for at risk patients and specific blood test monitoring for high risk patients with diabetes. The practice had advertised flu clinics within the surgery and on the practice website but there were no mechanisms in place for following up patients who did not attend. The practice had not demonstrated that it had taken any action to address their poor performance event though the practice was aware of their poor comparative performance.

Requires improvement

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were available in consulting and treatment rooms so that patients' privacy and dignity could be maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations.

Data from the national patient survey showed 77% of practice respondents stated the GPs and nurse were good at listening to them and 74% stated the GP gave them enough time. The practice was below the weighted CCG average for its satisfaction scores on consultations with doctors and nurses. The practice's own satisfaction survey completed in November 2013 did not ask patients' view in this area.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 27 completed cards. The majority were positive about the service experienced when seeing the GP or nurse. Patients said they felt listened to and supported. Two comments were less positive. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the GP and nurse, but two of these patients raised concern about the level of privacy at the practice's reception area.

We observed this also. Staff were not always careful to ensure confidentiality when discussing patients' and patients' treatments in the reception area. We overheard confidential patient information being discussed whilst in the patient waiting area. We also observed relatives being asked about patients' conditions in the reception area and over the telephone. National patient survey data showed only 67% of patient respondents were satisfied with the level of privacy when speaking to receptionists at the surgery. This was significantly below the national average on this matter.

Care planning and involvement in decisions about care and treatment

Data from the national patient survey showed 71% of practice respondents said the GP involved them in care decisions and 62% said the last nurse they saw or spoke to was good and involved them in decisions about their care. Three-quarters of the respondents said they felt the GP and the nurse were good at explaining treatment options and the results. These satisfaction rates were lower than the averages for the CCG area. Furthermore, the practice was not able to demonstrate how they involved patients in care planning. We were told that care plans for 2% of the most vulnerable patients had been created but these plans had not been shared with patients.

Staff told us that translation services were available for patients who did not have English as a first language. However, there was no information in reception or waiting area to inform patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The majority of CQC comments cards showed patients were satisfied with the emotional support provided by the GP and nurse. Patients we spoke with on the day of the inspection confirmed the GP and nurse provided good emotional support and were compassionate.

There was limited information about other groups and organisations in the waiting area to signpost and assist patients. There was one notice in the waiting room about support for child bereavement services. No other information was available in the patient waiting room or on the patient website relating to this area.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was not always able to respond effectively to patients needs and demands. The practice had implemented some suggestions for improvements and made some changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG) and patient survey completed in November 2013. For example, they had increased patient appointment times from 10 to 12 minutes.

The staff composition had remained stable and this enabled continuity of care for patients. However with only one GP for the majority of the time and one practice nurse, good and prompt access to a GP was not always easy. Longer appointments were available for people who needed them. Half-hour appointments were offered to patients with certain conditions such as mental health. Home visits were made to one local care home by the GP and to those patients who could not attend the surgery.

However, the practice struggled to maintain the level of service required. The needs of the practice population were not clearly understood by staff and systems were not in place to effectively address identified needs. There was no evidence that the practice used any risk tools to help the practice detect and prevent unwanted outcomes for patients.

The CCG visited the practice quarterly in order to discuss local needs and prioritisation of service improvements. We saw minutes of meetings where issues had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. However, there was little evidence to show that these actions had been taken forward.

Tackling inequity and promoting equality

We were told that anyone in the area who visited would get an appointment or be referred to the appropriate service. For example, people of "no fixed abode" or travellers. Information displayed within the practice indicated that patients could book extra-long appointments for specific conditions, such as mental health or drug addiction.

The practice could not provide us with evidence to show they had considered the needs of different patient groups when planning its services. The practice had access to telephone translation services.

The practice did not provide equality and diversity training for its staff. Staff had not completed any training on these issues in the last twelve months and there was no evidence to show equality and diversity was discussed within the practice.

Access to the service

All services for patients were on the ground floor. Ramp access was available at the front of the practice. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. The corridor to some of the treatment and consultation rooms was narrow and not easily accessible. Patients in wheelchairs or with prams could experience difficulty opening the doors. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. We were told the GP gave out their personal telephone number on occasions for patients to use in an emergency. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. This was observed on the day of the inspection, with priority given to vulnerable groups such as children.

Appointments were routinely available from 8am to 6.30pm on weekdays and until 8pm on a Wednesday. We were told the practice was flexible in accommodating patients' needs and often did early morning appointments from 6.30am. However, this was not reflective of the opening times detailed on the practice website. Text messages were used to remind patients of booked appointments. Home visits were carried out when the GP felt it appropriate. Data from the national patient survey showed only 68% of respondent patients were satisfied with the surgery's opening hours. This was below the weighted CCG average. Seventy percent of the respondents said they were able to get an appointment to see or speak to someone the last time they tried. Less than half of the respondents said they usually waited 15 minutes or less after their appointment time to be seen and nearly a third felt they didn't normally have to wait too long to be seen. Patients we spoke to on

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

the day of the inspection raised concern about the appointment waiting times and getting through to the practice via the telephone. Our observations on the day of the inspection and our experience of getting through to the practice before and after the inspection supported this view of how difficult it was to obtain access.

Limited information was available to patients about appointments on the practice website. There was no information about how to arrange urgent appointments and home visits. The practice did not offer any on-line services, for example for booking appointments.

Listening and learning from concerns & complaints

The practice had a complaints policy and system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person to handle complaints. However, there was no information available or on display in the waiting area or on the practice website to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

There were no complaint records available. We were unable to determine from conflicting discussions with staff whether any complaints had been received.

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 staff were clear they wanted to deliver good quality care. However, it was evident the practice lacked any vision or strategy about how it would deal with current and future changes and demand. There were no details of the practices vision and practice values displayed in the waiting areas and practice website, although after the inspection the practice provided us with a patient charter. The practice failed to show they had assessed the needs of their patient list in order to plan and provide services to meet their needs.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity. However, when we looked at these policies and procedures we found the practice did not have a system in place to assure them that these policies and procedures were being followed and implemented. For example, the practice had failed to identify that required training had not been completed in areas, such as safeguarding, chaperoning and fire safety training. The practice was also not following its own health and safety and recruitment policies. Furthermore, none of the policies had been reviewed within the last 12 months.

We noted that while the practice nurse was aware of some practice performance issues, for example relating to QOF, our discussions with the GP highlighted the GP was not aware of these.

There were no arrangements in place for identifying, recording or managing risks. Risks assessments were not carried out where risks had been identified or actions suggested. For example, as mentioned earlier there had been no action following the report on legionella testing.

Leadership, openness and transparency

Staff told us there was an open culture at the practice and informal meetings took place as and when needed. They said they felt supported and were clear about some aspects of their role, for example the practice nurse led on some clinical areas such as the management of long term conditions.

However, in the absence of a clear vision, strategy and suitable governance arrangements the practice failed to demonstrate effective leadership. While the practice had some policies and procedures on human resources and these were the responsibility of the practice manager, it was evident these were not actively used.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through a patient survey completed in November 2013. We saw the practice had acted on feedback and put measures in place to address issues raised. However, the practice had not monitored the impact of the changes introduced. For example, the practice had introduced measures to improve the management of telephone calls into the practice, but these changes were having a negative impact on patients waiting at the reception area. As noted earlier the responses to these concerns had not been monitored and the changes appeared to be ineffective.

The practice did not have a comments or suggestion box in the waiting area and no information on display on how to raise comments or suggestions.

We were told the practice had a PPG. The PPG last met over seven months ago. The practice website showed the PPG had considered the results and actions agreed from the last patient survey completed in November 2013. We did not speak with members of the PPG as the practice failed to provide the contact details of the chair and vice-chair that were requested on three occasions.

We were told the practice had not put in place mechanisms for gaining staff feedback as they were a small practice. We found there was no means for gaining staff feedback through appraisals or meetings. The practice did not have arrangements in place for "whistleblowing" by staff. These are issues that the practice does not appear to have addressed.

Management lead through learning & improvement

The practice nurse told us they were supported to maintain their clinical professional development through training and protected learning time. We were also told staff received external peer review. However, there were no staff files available and as such no records of staff appraisals or personal development plans. There was no system in place for monitoring that staff had completed the required training to enable them to carry out their role.

Are services well-led?

Inadequate

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

There was no evidence that the practice led through learning and improvement. The practice could not provide evidence of completed audit cycles or demonstrate they had taken action to improve their services in view of their poor performance in some areas, for example antibiotic prescribing. The practice had not completed reviews of significant events and other incidents in the last 24 months.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The practice did not have in place a sufficient number of administrative staff in order to facilitate the smooth running of the practice and to safeguard the health, safety and welfare of patients.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The practice demonstrated a fundamental lack of understanding of both "capacity" issues as outlined in the Mental Capacity Act and "safeguarding" as outlined in the local procedures and regulations. The practice did not always act in accordance with the consent of patients.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The practice did not ensure patients' medical records and personal details were held securely and remained confidential.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Compliance actions

The practice did not ensure that patients' dignity and privacy was maintained in relation to their care and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The practice did not ensure that effective systems were in place to assess the risk of and to prevent, detect and control the spread of health care associated infections.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The practice did not have suitable arrangements in place for assessing and monitoring the quality of service provision.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The practice did not operate effective recruitment procedures which ensured staff were fit to undertake their role.**