Swanpool Medical Centre

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Swanpool Medical Centre on 16 November 2016. The practice had previously been inspected in June 2015 and was found to be in breach of regulation 16 (complaints), regulation 17 (good governance) and regulation 19 (fit and proper persons employed). The practice was rated as requires improvement overall.

Following the previous inspection the practice sent us an action plan detailing the action they were going to take to improve. We returned to the practice to consider whether improvements had been made. We found the practice had made insufficient improvements to improve the service.

The breaches in relation to regulation 16 (complaints), regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been addressed and the practice was now compliant with these regulations. However, the breaches in relation to regulation 17 (good governance) had not been fully met. We also identified additional breaches in relation to regulation 12 (Safe care and treatment).

The practice is rated as requires improvement.

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

- The systems for reporting and recording significant events had not improved sufficiently since our previous inspection to support and improve safety in the practice. There was little evidence to show that clinical staff were involved in reporting and sharing incidents and their learning.
- There had been some improvements in the management of risks since our previous inspection for example, those relating to staff recruitment and fire safety. However we found weaknesses in relation to infection control, prescription safety and the follow up of actions required from the legionella risk assessment.
- Data showed patient outcomes were comparable to local and national averages in most areas.

Summary of findings

- There was little evidence that clinical audit was driving quality improvement in patient outcomes.
- Staff had the skills, knowledge and experience to deliver care and treatment.
- There was evidence of staff appraisals but these had not all been appropriately completed.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs however feedback received from community teams identified areas for improvement.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- We saw improvements in the management of complaints since our previous inspection. Information about services and how to complain was available and easy to understand and learning from complaints was shared at practice meetings.
- Patients said they did not always find it easy to make an appointment. Changes had been made to the appointment systems which had led to improvements such as a reduction in the number of non attendances and increased use of the on-line booking system.
- The practice was accessible to patients and equipped to treat patients and meet their needs.
- Governance arrangements were not sufficiently effective to ensure all staff groups were involved in supporting the service to improve.

The areas where the provider must make improvement are:

- The practice must improve governance arrangements for managing quality and safety.
- Ensure effective systems are in place for all staff (including clinical staff) to be involved in reporting and learning from incidents and complaints; for discussing and sharing best practice guidance and clinical audit
- Ensure safety alerts are consistently acted upon and for monitoring and acting on recommendations arising from risk assessments.
- Review and implement effective practice specific policies and share with staff.
- Ensure effective systems are in place for managing uncollected patient prescriptions.
- Ensure effective systems for managing prescription stationery.
- Ensure effective systems are in place for managing infection control within the practice.

The areas where the provider should make improvement are:

- Check that the thermometer on the medicines fridge is operating correctly to ensure that vaccinations are stored in line with public health guidlines.
- Review systems for managing equipment and medicines used in a medical emergency to ensure they can be accessed quickly with clear monitoring processes.
- Review the effectiveness of staff appraisals to ensure staff have the opportunity to discuss any learning and development needs.
- Review and develop effective multi-disciplinary working arrangements with the community teams.
- Ensure patients with a learning disability receive the opportunity for an annual health review.
- Continue to review patient feedback including feedback from the national patient survey and identify how the service might be improved.
- Review and implement policies that are practice specific and support staff in the day to day running of the practice.
- Review staff understanding and application of relevant consent and decision-making requirements for those who may lack capacity and children including the Mental Capacity Act 2005

Where a service is rated as inadequate for one of the five key questions or one of the six population groups, it will be re-inspected no longer than six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to 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?

Requires improvement

The practice continues to be rated as requires improvement for providing safe services.

- The systems for reporting and recording significant events had not improved sufficiently since our previous inspection to support and improve safety in the practice.
- Clinical staff, including locums and nursing staff rarely reported and discussed incidents.
- Systems for managing safety alerts did not demonstrate a consistent approach for ensuring they were acted on.
- The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse. There had been improvements since the previous inspection in relation to staff recruitment. However we found weaknesses in relation to the management of infection control and prescription safety.
- There had been some improvement in the management of environmental risks since our previous inspection for example fire safety. Risks to patients were assessed and in most cases managed but we found examples where recommendations had not been acted on.
- There were arrangements in place for managing medical and other emergencies that may arise.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were in most areas comparable to local and national averages.
- Evidence seen demonstrated that care was in line with current evidence based guidance. However, there was a lack of opportunities for discussing new guidelines including National Institute for Health and Care Excellence (NICE) best practice guidelines among clinical staff.
- There was little evidence that clinical audit was driving improvement in patient outcomes.
- Staff had the skills, knowledge and experience to deliver care and treatment.
- There was evidence of staff appraisals but these had not all been appropriately completed.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs however feedback received from community teams identified areas for improvement.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey (published July 2016) showed patients rated the practice lower than others for several aspects of care. For example, 66% of patients described the overall experience of this GP practice as good compared to the CCG average of 75% national average of 85% and 69% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% national average of 82%.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice was participating in the CCG led primary care commissioning framework aimed at improving services and patient outcomes.
- Feedback from patients told us that they did not always find it easy to make an appointment. However, we saw that action had been taken to try and improve access. This had resulted in less non attendances and greater use of on-line appointments.
- The practice was accessible to patients and equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff through practice meetings.

Summary of findings

Are services well-led?

Inadequate

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

- The practice had failed to make sufficient improvements since our previous inpsection and is now rated as inadequate for being well-led. Over the last two years the practice had sought to bring together two GP practices that had formerly shared the premises. There was a heavy reliance on locum staff to deliver the service and the principal GP had shared work commitments at other practices.
- There was a clear leadership structure and staff felt supported by management.
- Practice performance against QOF was monitored and showing year on year improvement.
- Governance structures were in place however, these were not effective in ensuring risks to patients safety and the service were shared and discussed with all staff groups. There had been little improvement in this area since our previous inspection in June 2015.
- The practice had a number of policies and procedures to govern activity but these had not all been made practice specific and fully utilised by staff to support the delivery of the service. There had been little improvement in this area since our previous inspection in June 2015.
- The practice had not displayed the rating following our previous inspection.
- The practice had sought feedback from staff and patients, which it acted on in relation to access.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

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

The provider is rated as inadequate for providing well-led services and requires improvement for providing safe, effective, caring and responsive services. The issues identified as requires improvement overall affected all patients including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits for those who needed them.
- The practice worked as part of a multi-disciplinary team to support those with end of life care needs. However, based on feedback received by CQC from a patient and community staff the arrangements did not assure us that patients would receive timely care.
- The practice offered flu vaccinations.
- The premises were accessible to those with mobility difficulties.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

The provider is rated as inadequate for providing well-led services and requires improvement for providing safe, effective, caring and responsive services. The issues identified as requires improvement overall affected all patients including this population group.

- All clinical staff took responsibility for managing patients with long term conditions.
- Performance against QOF was mostly in line with the CCG and national averages for many long term conditions.
- However, performance for diabetes related indicators (2015/16) was 79% which was below the CCG average of 88% and national average of 90%. The practice had taken some action and early indicators from practice data (unvalidated) was showing signs of improvement.
- Patients with a long term condition received a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people.

The provider is rated as inadequate for providing well-led services and requires improvement for providing safe, effective, caring and responsive services. The issues identified as requires improvement overall affected all patients 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 A&E attendances.
- Immunisation rates were relatively high for standard childhood immunisations.
- Uptake of cervical screening (2015/16) was at 81% was similar to the CCG average 79% and national average 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We did not receive a clear response as to whether children would be seen alone if they wished to speak in confidence.
- Antenatal and postnatal checks were available by appointment.

Working age people (including those recently retired and students)

Requires improvement

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

The provider is rated as requires improvement for providing well-led services and requires improvement for providing safe, effective, caring and responsive services. The issues identified as requires improvement overall affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible.
- The practice had recently introduced extended opening hours on a Saturday morning for the convenience of those that worked or had other commitments during normal opening hours.
- The practice was proactive in offering online services (including online appointments and repeat prescriptions).
- The practice offered a range of health promotion and screening that reflects the needs for this age group.

Summary of findings

- The practice made use of texting to remind patients of appointments and for ease of cancelling if appointments were no longer needed. Texts were also used to obtain feedback from patients with the Friends and Family test.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

The provider is rated as inadequate for providing well-led services and requires improvement for providing safe, effective, caring and responsive services. The issues identified as requires improvement overall affected all patients including this population group.

- The practice held registers of patients living in vulnerable circumstances such as patients with a learning disability and those with caring responsibilities.
- The practice had signed up to the learning disability enhanced service.
- There were 40 patients on the learning disability register of which 11 (28%) had received a health review in the last 12 months.
- The practice had identified 103 patients as carers (1.2% of the practice list). Information was available to signpost carers to support available. They were also offered annual flu vaccinations.
- Practice staff told that they did not currently have anyone registered with no fixed abode but would register using the practice address if necessary. They also told us that they had registered travellers and asylum seekers in the past.
- Staff had undertaken training on domestic violence and supported those at risk through the signposting and referral to a local support programme (IRIS).
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

The provider is rated as inadequate for providing well-led services and requires improvement for providing safe, effective, caring and responsive services. The issues identified as inadequate overall affected all patients including this population group.

Summary of findings

- Nationally reported data for 2015/16 showed 81% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG and national average 84%.
- National reported data for (2015/16) showed 87% of patients with poor mental health had comprehensive, agreed care plans documented, in the preceding 12 months which was comparable to the CCG average of 91% and national average 89%.
- The principal GP held a dedicated dementia clinic to support early diagnosis and care.
- Practice staff told us that counselling services were provided in-house.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016. The results showed the practice was performing below local and national averages. A total of 321 survey forms were distributed and 115 (36%) were returned. This represented 1.4% of the practice's patient list.

- 40% of patients found it easy to get through to this practice by phone compared to the CCG average of 60% and national average of 73%.
- 42% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 61% and national average of 76%.
- 66% of patients described the overall experience of this GP practice as good compared to the CCG average of 75% national average of 85%.
- 42% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 66% and the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards, 16 were positive about the standard of care received and found the staff polite and helpful. However we also received nine that were less positive and raised issues about difficulties accessing the services, attitude of staff (both clinical and non-clinical) and being asked in reception why you want to see the doctor.

We looked at comments on the NHS Choices website. There were 14 made in the last year and 12 of these raised issues about access, staff attitude and care.

The latest available data from the practice for the friends and family test (August 2016) which invites patients to say whether they would recommend the practice to others showed 60% of patients would recommend the practice based on 106 responses.

Swanpool Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector, a GP specialist adviser and a practice manager specialist adviser.

Background to Swanpool Medical Centre

Swanpool Medical Centre is part of the NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Swanpool Medical Practice is located in purpose build accommodation. An independent pharmacy operates from within the practice. All clinical services are provided on the ground floor. The practice list size is approximately 8500 patients. Services to patients are provided under a General Medical Services (GMS) contract with NHS England.

Based on data available from Public Health England, the practice is located in one of the most deprived areas nationally and within the 10% of most deprived areas.

Practice staff consist of the principal GP (male) who undertakes three clinical sessions each week at the practice and four regular long term locum GPs (three male and one female). Other practice staff include two practice nurses, a practice manager, an IT Manager and a team of administrative / reception staff.

The practice is open Monday to Friday 8 am to 6.30 pm. Appointment times vary between the clinical staff but usually range from 8.30am to 12.20pm and 2.30pm to 5.50pm. When the practice is closed services are provided by an out of hours provider which are reached through the NHS 111 telephone service. The practice provides extended opening hours on a Saturday morning between 9am and 12 noon.

The principal GP, Dr Manivasagam is also the provider for two other practices Bean Road Medical Practice and Stone Cross Medical Centre.

The practice runs a pain clinic and a minor surgery clinic from the premises which are available for both registered and non-registered patients.

The practice was previously inspected by CQC in June 2015. The practice was rated requires improvement overall and was found to be in breach of regulations 16 Receiving and acting on complaints, 17 Good Governance and 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Why we carried out this inspection

This inspection was undertaken to follow up progress made by the practice since their previous inspection in June 2015.

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 November 2016. During our visit we:

- Spoke with a range of clinical and non-clinical staff (including the principal GP, three locum GPs, a practice nurse, the practice manager, the IT manager and administrative/reception staff)
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Observed how people were being cared for.
- Spoke with members of the practice's Patient Participation Group.
- Spoke with members of the community health team.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed documentation made available to us for the running of the practice.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

At our previous inspection in June 2015 we identified concerns in relation to the management of incidents and safety alerts. At this inspection the practice was still unable to demonstrate that an effective system was in place.

There was a system in place for reporting and recording significant events. However, the systems in place were not sufficiently effective in ensuring that when things went wrong learning took place.

We reviewed incidents and significant events that had been reported in the last 12 months in which there had been eight. Those reported related to aggressive patients, errors made by other organisations and administrative issues. There had been no recorded practice incidents of a clinical nature. We were told about three separate incidents from members of the staff team and community team on clinical issues that were not included within the report shared with us. The practice were unable to demonstrate that these incidents had been recorded and appropriately managed.

We received mixed information about how incidents were discussed and shared with clinical staff to support learning. We saw evidence that there had been discussions at the practice meetings, however these were rarely attended by the locum GPs and nursing staff. We were told that the practice held weekly clinical meetings and incidents were discussed there but the minutes seen showed there had only been two clinical meetings in the last year and significant events had only been discussed at one of these in February 2016.

Since our previous inspection in June 2015 we saw that there had been some improvements in the management of safety alerts received such as those from the Medicines and Healthcare Products Regulatory Agency (MHRA). These were now circulated among clinical staff who signed to say they had seen them. Practice staff told us that the principal GP actioned them. We saw evidence from patient records that some alerts had been acted on but this was not consistently the case. Records were not actively maintained to show what action if any had been taken.

Overview of safety systems and processes

The practice systems, processes and practices in place to keep patients safe and safeguarded from abuse were not sufficiently robust:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. There was a safeguarding board in the office behind reception which contained contact details and reporting arrangements for safeguarding concerns. The principal GP was the lead member of staff for safeguarding. At our previous inspection in June 2015 we found not all clinical staff had received safeguarding training. At this inspection we found all clinical staff were trained to and appropriate level for their roles and all the GPs were trained to child safeguarding level 3 . Some staff had also completed training in domestic violence awareness. An alert on the patient record system ensured clinical staff were aware at the point of contact if a patient was at risk.
- Notices displayed throughout the practice advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Evidence seen during the inspection did not assure us that appropriate standards of cleanliness and hygiene were maintained. We saw completed cleaning schedules in place but this did not include equipment such as the examination couches. We looked in several clinical rooms and noticed one of the couches looked stained and another had dirt trapped in the piped edging. There was no records kept for the cleaning of clinical equipment and only the nurses room contained wipes. We asked clinical staff how they cleaned their equipment and couches and were advised it was with hand rub. We were advised that the disposable privacy curtains were changed 12 monthly however there was no clear protocol for this and one of the curtains seen was soiled.
- The practice nurse was the infection control clinical lead, we saw that they had undertaken infection control training. The lead nurse told us they had carried out a handwashing audit but was not aware of any other infection control audits. For the hand washing audit only one form had been completed for all staff at the practice so it was difficult to know if there were any

individual issues or if anyone had been missed. The practice manager later showed us an infection control audit undertaken in September 2016 but this did not raise any concerns. The practice manager advised us that the CCG was going to do an infection control audit but that this had cancelled because it was the same day as the CQC inspection. We asked one of the reception staff handling a specimen during our visit if they had received any training in handling specimens they told us that they had not.

- We reviewed the practice's arrangements for managing medicines, including emergency medicines and vaccines. We reviewed 10 patients on high risk medicines which require regular monitoring and review and found all were appropriately managed. The practice was able to access pharmacy support through the CCG and attended quarterly meetings with them. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, we also identified uncollected prescriptions that dated back to August 2016, we asked staff what happened to these. They told us that they were checked the prescription box on an adhoc basis and made a note in the patient records but there were no circumstances in which they would highlight an uncollected prescription to the GP. The systems for recording prescription stationery did not ensure an accurate audit trail was maintained should any go missing, this had also been identified at our previous inspection in June 2016. We also noticed that one of the vaccine fridges had the same current, minimum and maximum recorded daily temperature for the last three months. We were assured that staff knew how to reset the fridge thermometer but this had not been raised as a potential concern by staff. We discussed the need to look into this with the practice.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We also saw evidence of appropriate checks for locum staff.

Monitoring risks to patients

We saw some progress since our previous inspection in June 2016 in the management of risks but further work was still required.

- We found the premises was in need of some refurbishment. The health and safety poster displayed identified the principal GP as the health and safety representative.
- We saw risk assessments in place in relation to fire, the control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We saw some improvements in fire safety since the previous inspection. The practice had carried out routine fire alarm checks and had recently undertaken a fire drill. The majority of staff had now completed fire safety training.
- However, it was not evident that recommendations following the risk assessments were always followed up for example, the legionella risk assessment (dated January 2014) recommended the checking of water temperatures which had not been carried out in the time since the risk assessment had been completed.
- Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. These had been completed in the last 12 months.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The principal GP told us that he attended the practice daily to manage post and patient information for example, test results that came in, they told us that this would be delegated to one of the locums in their absence. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There were limits to the number of staff that could take leave at any one time. Reception roles were shared so staff were able to support each other.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to 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.
- Staff had received annual basic life support training. A practice training session had been undertaken for all staff in the practice.

Requires improvement

Are services safe?

- Information relating to resuscitation guidance was displayed around the practice.
- The practice had a defibrillator available on the premises and pads were in date and oxygen was available. We saw adult masks but no children's masks.
- Emergency medicines were available in the treatment room and those checked were in date and stored securely. Staff knew of their location.
- We found the storage of emergency medicine and equipment a little disorganised and held in different places. Some equipment seen such as airways were no longer sealed and therefore difficult to know if they had been previously used and were unprotected from dust and other soiling.
- There was some confusion as to who checked the emergency medicine and equipment. Checks seen by the nurse were recorded in a diary and carried out on an adhoc basis. At feedback the practice manager told us that they also carried out checks on a more frequent basis. Neither the nurse or practice manager were aware that each other was doing this.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. There were details about reciprocal arrangements with another practice should the premises become unavailable. Contact numbers for services were available but did not include staff contacts. The practice manager advised us that a copy was also kept of site.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Records seen showed care and treatment in line with best practice guidance.
- Clinical staff saw it as their own responsibility to keep up to date with best practice for example, through reading clinical journals.
- The locum GPs spoke of meetings they attended outside the practice with speakers which enabled them to keep up to date.
- Two members of the community team told us that they had tried to share latest guidance with the practice but found it difficult speaking with clinical staff.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were for 2015/16. This showed the practice had achieved 95% of the total number of points available, which was comparable to the CCG and national average of 95%. Overall exception reporting by the practice was 8% compared to the CCG and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/2016 showed:

- Performance for diabetes related indicators was 79% which was lower than the CCG average of 88% and national average of 90%. Exception reporting in eight out of the two diabetes indicators was lower than the CCG and national averages.
- Performance for mental health related indicators was 98% which was higher than the CCG average of 91% and national average of 93%.

We asked the practice about what action they had taken to improve outcomes for patients with diabetes.

- The practice told us that they had been more proactive in trying to contact diabetic patients for review. We looked at the progress that had been made against QOF for 2016/2017 and we saw evidence of improvement. For example, progress to date for QOF 2016/2017 (with four months still to go) showed the practice had achieved 67% of total QOF points for patients that had a HbA1c of below 64. (HbA1c is an indicator of diabetic control, those under 64 are generally considered better controlled). During 2014/15 and 2015/16 the practice achieved 68% against this indicator.
- We reviewed the records of five patients with diabetes and found that these patients had received regular review and had been managed appropriately.
- The practice also hosted a clinic with a visiting diabetic specialist nurse every two months who reviewed some of the more complex patients. A local diabetes consultant was also available for advice if needed.

There was some evidence of quality improvement such as clinical audit but these did not demonstrate how they were supporting service improvement. One was a fully cycle audit.

- The practice shared with us an audit in which the management of patients with atrial fibrillation (heart conditions) was reviewed against NICE guidance. Although we saw an overall improvement in stroke risk in the practice population, these improvements appeared coincidental rather than as a result of changes. For example, for five out of seven cases in which the patients had been reviewed as high risk the treatment regime had been unchanged.
- Other audits presented included a diabetes audit as part of local incentive scheme which provided benchmarking information with other practices in the CCG which identified areas the practice needed to focus on QOF.
- There were two prescribing audits undertaken with the view to change or reduce prescribing.
- Other audits seen included a minor surgery audit 2015/16 which reviewed appropriateness of referral, infection and patient satisfaction.

Prescribing data seen showed the practice prescribing in relation to antibiotics and hypnotics in line with other practices.

Requires improvement

Are services effective?

(for example, treatment is effective)

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. We spoke with two new members of staff who confirmed they had received induction training at the practice and were happy with the support received.
- New members of staff received a three monthly review to discuss their progress. This was confirmed by two new members of staff we spoke with who told us that they were happy with the support they received.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- We saw that staff received annual appraisals. However, the quality of appraisals varied. We found some that had not been appropriately completed by the appraiser and included only the member of staffs self assessment.
- Staff had access to and made use of e-learning training modules and in-house training that included: safeguarding, fire safety awareness, basic life support and information governance. Training records seen showed that most staff had completed much of the training in the last couple of weeks prior to the inspection. There were no clear systems in place for monitoring that staff remained up to date with relevant and appropriate training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. The principal GP took sole responsibility for acting on patient correspondence and test results. Staff told us that the principal GP came in every day to do this even when not working clinical sessions.

The principal GP met with other health care professionals every two months to discuss and review the care of the practice's most vulnerable patients including those with complex and end of life care needs. We saw minutes from these meetings and spoke with three members of the community health team.

Members of the community health team confirmed that regular meetings took place but did not always find the clinical staff at the practice approachable and raised a number of issues including issues relating to prescribing for palliative care patients and writing do not attempt resuscitation orders. They also raised a lack of understanding among non-clinical staff as to the urgency when palliative care patients were running low on medicines.

Consent to care and treatment

At our previous inspection in June 2015 we found staff did not have a good understanding of relevant consent and decision-making requirements including the Mental Capacity Act 2005. At this inspection there was little evidence of improvement. We were advised that staff had undertaken training in the Mental Capacity Act but training records seen showed that only the principal GP out of all the clinical staff had completed this.

The practice leaflet said it preferred patients under 14 to be accompanied by a parent or guardian and one locum GP said that reception staff would insist on it.

Supporting patients to live healthier lives

The practice provided some lifestyle support to patients directly in areas such as smoking cessation or by referral to the health exchange. The practice also made use of route2wellbeing website which signposts patients to local support organisations.

The practice's uptake for the cervical screening programme (2015/16) was 81 %, which was comparable to the CCG average of 79% and the national average of 82%. There were systems in place for ensuring results were received for samples sent for the cervical screening programme and for following up patients who did not attend.

The uptake of national screening programmes for bowel and breast cancer screening were comparable to the CCG average but lower than national averages. For example,

Requires improvement

Are services effective?

(for example, treatment is effective)

- 67% of females aged 50-70 years of age had been screened for breast cancer in the last 36 months compared to the CCG average of 67% and the national average of 72%.
- 49% of patients aged 60-69 years, had been screened for bowel cancer in the last 30 months compared to the CCG average of 46% and the national average of 58%.

We saw information displayed promoting breast screening displayed in the practice.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 97% compared to the CCG average of 52% to 94% and national average of 73% to 95% and five year olds from 95% to 98% compared to the CCG average of 55% to 95% and the national average of 81% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

The practice offered patients with a learning disability the opportunity of a health review. In the last 12 months these had been received by 11 out of 40 patients (28%) on the learning disability register.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During the inspection we observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Staff told us that if a patients wanted to discuss sensitive issues or appeared distressed they would offer them a private room or somewhere quieter to discuss their needs. There was a notice displayed in reception advising patients off this.

We received a mixed response from the 26 Care Quality Commission comment cards we received from patients. Of those 16 were positive about the service experienced, patients said they were satisfied with the care and that they found staff polite and helpful. However we also received nine comment cards in which patients were less positive, most of these related to access but there were also comments about the attitude of staff (both clinical and non-clinical) and patients being unhappy at being asked in reception why they wanted to see the doctor.

Results from the national GP patient survey (published in July 2016) showed practice scores were below CCG and national averages in relation to its satisfaction scores on consultations and helpfulness of reception staff. For example:

- 73% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 77% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 86% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 70% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 85%.
- 83% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 91%.
- 74% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%.

There were no action plans in place to address the below average scores in relation to the questions about the quality of consultations and helpfulness of the reception staff from the national GP patient survey.

The practice had reported several incidents involving aggressive patients. Staff told us that these were not always the same patients. Four of the eight reported incidents related to aggression. We noticed that grilles were used at the reception desk which we were told was due to aggression towards reception staff. Most of the administrative staff had completed the online training for managing conflict or aggression towards them.

Care planning and involvement in decisions about care and treatment

Records seen for palliative care patients showed a patient-centred approach with involvement of the multi-disciplinary team, patients and families in the care.

Results from the national GP patient survey (published July 2016) showed patient responses to questions about their involvement in planning and making decisions about their care and treatment were slightly lower than local and national averages. For example:

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 69% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% national average of 82%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 85%.

The practice provided some facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Requires improvement

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area and in clinical rooms which told patients how to access a number of support groups and organisations. Information was also available on the practice website which signposted patients to further information.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 103 patients as carers (1.2% of the practice list). There was a carers pack in reception which staff could use to signpost or copy for patients. A carers noticeboard was available in reception inviting patients to notify the practice if they were a carer. Links to carers information was also available on the practice website.

The practice had a bereavement pack which it could refer patients to support available. We saw a recent example in which a card had been send to the family in condolence.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was participating in the primary care commissioning framework led by the CCG aimed at improving services and patient outcomes as well as consistency in primary care services.

- The practice provided extended opening hours on a Saturday morning for the convenience of patients who worked or had other commitment during the week.
- There were longer appointments available for patients who needed them.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice, most but not all of the locum GPs undertook home visits. However we did see examples from this week of home visits that had been undertaken.
- Patients were able to receive travel vaccinations available on the NHS and had details readily available for yellow fever clinics.
- The practice was accessible to those with mobility difficulties and there was sufficient space for wheel chair access.
- The practice had a hearing loop and translation services were available. The self check in was also displayed in different languages.
- The practice had baby changing facilities.
- Services such as Phlebotomy provided by the local hospital (weekly) and electrocardiographs (ECGs) were available in-house for the convenience of patients.
- Other in house services included minor surgery and a pain clinic. These were available to registered and non registered patients. The pain clinic was carried out by one of the locums forseven sessions each week and the minor surgery from a visiting plastic surgeon for two sessions each month.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointment times varied between the clinical staff but usually ranged from 8.30am to 12.20pm and 2.30pm to 5.50pm. Extended hours appointments were offered on a Saturday morning between 9am and 12 noon.

In addition to pre-bookable appointments that could be booked up to one week in advance, same day appointments were available which were released at 8am each morning. The availability of urgent appointments depended on the GPs on duty some would see extra patients. When the practice was closed patients were transferred to the out of hours provider via the NHS 111 telephone number.

We saw that the next available routine appointment was within five working days for a GP, one working day for the practice nurse and four working days for a blood test. Patients requiring a blood test could attend as a walk in patient at another local health centre or the local hospital.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages, particularly in relation to ease of getting through on the telephone..

- 67% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 79%.
- 40% of patients average of 73%.said they could get through easily to the practice by phone compared to the CCG average of 60% and national

Nine out of the 26 patients who provided feedback through the completed CQC comment cards said they had difficulties accessing appointments.

The practice had carried out its own appointment survey of 142 patients during 2015/16 to try and identify the issues around access. They also identified a high number of patients who did not attend their appointments. Changes were made to the appointment system reducing advance bookings from two weeks to one week. Patients were encouraged to use the on-line appointment system and a Saturday morning clinic was introduced. Following the changes the practice was able to show a reduction in the number of patients who did not attend their appointment by 230 over a three month period. There was also an increase of 150 patients using the online appointment system.

Listening and learning from concerns and complaints

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

At our previous inspection in June 2015 we had found the practice did not have an effective complaints system and that the complaints process had not been consistently followed. At this inspection we found improvements had been made and complaints effectively managed.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- A complaints leaflet was available on request which contained details about the expected timescales for a response to their concern and what to do if they are not happy with the response received. Information about how to complain was also included in the practice leaflet.

The practice had received 24 complaints in the last 12 months these mainly related to appointments, staff attitude and prescription issues. We reviewed two complaints and found that these had been appropriately managed in a timely way. Learning from complaints were shared at the practice meetings.

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 formed following a merger of two GP practices that had shared the premises in June 2014. Over the last two years the practice had sought to bring together the two practices, however there was a high use of locum GPs to cover clinical sessions who were not engaged in the clinical leadership of the practice.

There was a practice charter and mission statement for the practice. This set out what patients can expect from the service and what the practice expect in return.

Governance arrangements

The practice had an overarching governance framework in place.

We saw some positive arrangements in place for example,

- The practice had a good understanding of performance and had dedicated IT support to monitor QOF and other performance at the practice. QOF performance had improved from 91% during 2014/15 to 95% in 2015/16.
- There were structures in place for the dissemination of information to all staff through regular practice meetings.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities.

However, we also found:

- Responsibility for the governance of the practice lay with the principal GP and practice manager. The principal GP was also the provider for two other practices. All other GPs who worked at the practice did so on a locum basis, the practice was unable to demonstrate how they ensured effective communication with all staff including locum GPs to discuss and share learning from incidents, complaints and risks.
- Policies and procedures were in place but these were not always practice specific, for example policies and guidance around specimen handling was not consistent with practice processes. The infection control lead was unable to locate the practice infection control policy when asked.
- The practice was not proactive in using clinical audits to drive quality improvement.
- Although, we saw some improvement in the management of risks to the health and safety of patients and staff since the previous inspection in June 2015 these improvements had not gone far enough.
- The practice had not displayed their rating following the previous CQC inspection.

Leadership and culture

During our inspection we were not confident of the leadership capacity in the practice. The practice received feedback that was consistently below CCG and national averages in relation to access and quality of consultations from the national GP patient survey. Community staff did not describe effective multi-disciplinary team working arrangements and staff found the GPs variable in their approachability.

Staff told us that the practice held regular team meetings to share important information and these were well attended by the non-clinical staff and principal GP. However, there was a lack of consistency in attendance by other clinical staff and were rarely attended by the locum GPs or nursing staff.

We were told that clinical meetings took place most weeks but we saw only two sets of minutes available for the last year and the clinical staff we spoke with gave varying responses as to how often they took place and whether they attended. They were also unable to confirm that as a practice they took part in regular discussions relating to incidents, safety alerts and NICE guidance. There was a lack of reporting of clinical incidents.

Staff told us they felt supported by management and that the principal GP was contactable by telephone when not working at the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) of which there were approximately five active members. We spoke with two members of the PPG who told us that they met regularly. The principal GP and practice manager attended those meetings. They told us that

Are services well-led?

Inadequate

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

they felt listened to and that the practice had improved over the last 18 months. They told us about improvements such as the new television display for calling in patients in for their appointments. There had also been changes to the appointment system to try and improve access. The practice also made use of texting to obtain feedback from patients with the Friends and Family test.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The practice did not have effective systems in place for managing infection control. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not have robust systems to ensure patients were protected against the risk of unsafe or inappropriate care and treatment. • Clinical staff did not effectively participate in the reporting of incidents and learning from them. • Safety alerts were not consistently acted upon. • There was a lack of effective arrangements for sharing and discussing best practice guidance, audit findings and complaints with all clinical staff. • Systems for monitoring risk assessments and ensuring recommendations from them were implemented were not consistently effective. • The practice lacked practice specific policies and procedures which were shared and understood by all staff. • Feedback from patients including from the GP national patient survey was not effectively used to support service improvement. • Systems were not in place for managing uncollected patient prescriptions and for monitoring prescription stationery. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.