Beehive Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Beehive Surgery on 15 June 2017. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice had carried out a fire risk assessment that had failed to identify serious failures, such as there were no in-date fire extinguishers on the premises.
- The practice had no clear leadership within the practice. For example, the GP partners had a dysfunctional relationship and issues that had been identified around the daily working arrangements lacked structure.
- Children and young people were not always treated in an age-appropriate way and recognised as individuals.
- Incident reporting was inconsistent, and we saw evidence of a significant event that had not been recorded. Discussion around significant events was not recorded and learning outcomes were not reviewed.
- Patients were usually positive about their interactions with staff and said they were treated with compassion and dignity.
- Although patients were able to access appointments they told us there were long waiting times at the practice.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients.

Summary of findings

- Ensure that any complaint received is investigated and any proportionate action is taken in response to any failure identified by the complaint or investigation.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Patients did not always receive a verbal and written apology.
- Significant events were not consistently recorded and discussion in meetings around learning was not recorded.
- Fire extinguishers were all out of date by up to 20 years and this had not been identified by the fire risk assessment carried out in May 2017.
- Some medicines and vaccines were kept in an unlocked fridge in a room where the fire door was propped open. Emergency medicines were also kept in this room in a locked cupboard, but the key was kept on top of it.
- One of the partners stated they had been trained to safeguarding children level two, but there was no evidence to demonstrate this.
- Although there was a policy that prescriptions would not be handwritten, one partner stated they kept blank prescriptions at home to write during home visits. We were told these prescriptions were not recorded.
- The business continuity plan was not accurate. It stated there was an emergency box in the treatment room but we found this did not exist. In addition it stated that in the case of electricity loss candles would be used.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- There was no evidence that clinical audits were driving improvement in patient outcomes.
- GPs told us the care of patients with long term conditions was mainly opportunistic and there was no recall system.
- There was inconsistency in the way patients under the age of 16 were treated. Although the GP had a good understanding of

Summary of findings

Gillick competence (used to determine the understanding and competence of young patients) the website stated patients under the age of 16 needed to have a parent present, and reception staff confirmed this.

- Training was not well organised or recorded, and not all staff had had an appraisal.
- Although the Choose and Book service was used with patients, giving patients a choice of place, date and time for outpatient appointments, we saw 26 patients referred since February 2017 had not yet made an appointment. This was brought to the attention of the lead GP.
- Data showed the practice was performing in line with local and national averages.
- Multi-disciplinary working was taking place and meetings were recorded.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Clinical complaints were routinely dealt with by the clinician involved. They were not monitored and not responded to appropriately. We saw no evidence of learning from complaints.
- Although patients could access appointments they told us there was a long waiting time at the practice. We saw evidence of a partner arriving late for surgeries and leaving part way through a surgery.
- Same day appointments were available for children under the age of 10 years, and patients received a text reminder prior to their appointment.
- The practice was planning improvements to the practice building and was in the process or arranging funding.

Are services well-led?

Inadequate

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

Summary of findings

- The practice did not have a clear vision and strategy. There was no formal business plan.
- Although one of the partners acted as lead GP there was inconsistency in how matters were dealt with and several issues had not been resolved.
- We saw an example of an issue identified at the practice that had not been raised as a significant event and patients and other people involved had not been informed of the issue.
- There was no programme of continuous clinical and internal audit to monitor quality and to make improvements.
- Although we saw evidence of regular meetings these were not well-recorded so it was difficult to see what had been discussed.
- Several issues were found during the inspection that the practice did not have an understanding of. These included issues relating to fire safety and how complaints should be dealt with.

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

- The practice carried out medicine reviews for older patients, but these were not always correctly coded.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. Care plans were in place that were reviewed regularly.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Regular palliative care meetings took place with a multi-disciplinary team.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The provider was rated as inadequate for safe, responsive and well-led, and as requires improvement for effective. The issues identified as requiring improvement overall affected all patients including this population group.

- Nursing staff did not have lead roles in long-term disease management. There was no recall system and care was largely opportunistic carried out by GPs.
- Medicine reviews were not well managed; the practice did not know how many had been carried out as they were not coded correctly.
- Performance for diabetes related indicators was 90%. This was above the CCG average of 88% and the same as the national average. The exception reporting rate was 2% compared to the CCG average of 8% and the national average of 13%.

Summary of findings

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for safe, responsive and well-led, and as requires improvement for effective. The issues identified as requiring improvement overall affected all patients including this population group.

- Although the safeguarding lead had been trained in safeguarding children to level three there was no evidence the other partner had been trained and they told us this was to level two, which is not the appropriate level.
- Reception staff and the website stated patients under the age of 16 could not be seen without an adult present. GPs and the practice manager stated this was not correct.
- Immunisation rates were in line with the CCG and national averages for all standard childhood immunisations.

  Appointments were available outside of school hours and the premises were suitable for children and babies.
- Children under the age of 10 years could access same day appointments.

Working age people (including those recently retired and students)

Inadequate

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

- Although the practice stated they carried out health checks for patients over the age of 40 they were unable to say how many had been completed. This information was provided following the inspection.
- The practice opened late every Thursday to make it easier for working patients to access appointments.
- Appointments could be accessed on-line.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safe, responsive and well-led, and as requires improvement for effective. The issues identified as requiring improvement overall affected all patients including this population group.

Summary of findings

- Although the practice had no homeless patients there was a system in place to register patients without an address.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. However, there was no evidence one GP had been trained to the required level.

People experiencing poor mental health (including people with dementia)

Inadequate

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

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was above the CCG and national average.
- Performance for mental health related indicators was 100%. This was above the CCG average of 92% and the national average of 93%. The exception reporting rate was 0% compared to the CCG average of 8% and the national average of 13%.
- The practice told us mental health teams often carried out the mental health reviews and dementia reviews were carried out during routine reviews on patients in nursing homes.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in July 2017. The results showed the practice was usually performing below local and national averages. 372 survey forms were distributed and 93 were returned. This was a completion rate of 25%, representing represented 3% of the practice's patient list.

- 77% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 87% and the national average of 85%.
- 72% of patients described their experience of making an appointment as good compared with the CCG average of 76% and the national average of 73%.
- 61% 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 78% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 45 comment cards. Thirty-nine of these were wholly positive, stating that staff were friendly and caring, and emergency appointments could be accessed. Other patients made comments about issues with the availability of appointments, the lengthy waiting time and the building requiring updating.

We spoke with nine patients, including two members of the patient participation group (PPG), during the inspection. Patients were generally happy with the care they received. Four patients told us it was difficult to get through to the practice on the telephone. All patients told us appointments were easily available.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Ensure that any complaint received is investigated and any proportionate action is taken in response to any failure identified by the complaint or investigation.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Beehive Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Beehive Surgery

Beehive Surgery is located in a converted terraced house in a residential area in Bolton, 108 Crescent Road, Great Lever, Bolton, BL3 2JR. There were two floors with patient access to both floors. A stair lift was available. There was on-street parking.

At the time of our inspection there were 3035 patients registered with the practice. The practice is a member of NHS Bolton Clinical Commissioning Group (CCG). The practice delivers commissioned services under the General Medical Services (GMS) contract.

There are two male GP partners; one partner works nine sessions per week and the second partner works three sessions per week. A female locum GP is available and works three sessions per week. The same female locum also works as the practice manager. A part time locum practice manager is at the practice to assist the practice manager. There is also a locum practice manager, a locum practice nurse, and a healthcare assistant. There are three reception staff supporting the clinical staff.

Opening hours are usually 8am until 6.30pm Monday to Friday, and the practice offers extended hours opening until 8pm on Thursdays.

Surgery times are:

Monday 9.30am to 2pm and 4pm to 6.30pm

Tuesday 9.30am to 12.30pm and 4pm to 6.30pm

Wednesday 9.30am to 12.30pm and 5pm to 6.30pm

Thursday 9.30am to 12.30pm and 4.30pm to 8pm

Friday 9.30 to 12.30pm and 4.30pm to 6.30pm

The practice has a below average number of patients over the age of 44, with very few patients over the age of 80. There is an above average number of patients aged under the age of 20 and in the 25 to 34 age group.

The male life expectancy is 76 years, below the national average of 79 years. The female life expectancy is 79 years, below the national average of 83 years. An above average number of patients were unemployed.

There is an out of hours service available by phoning NHS 111. The out of hours provider is BARDOC.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 such as the clinical commissioning group (CCG) and NHS England to share what they knew. We carried out an announced visit on 15 June 2017. During our visit we:

- Spoke with a range of staff including the GP partners, the practice manager/locum GP and reception and administrative staff.
- Spoke with patients who used the service.
- Observed how patients were being cared for in the reception.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.
- Looked at policies and procedures in place.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

The system for reporting and recording significant events was not effective.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed significant event records kept by the practice. We found that they were not consistently recorded and we saw an example of a significant event that had not been recorded. Staff told us that significant events were discussed in meetings. However, the practice manager told us this was not recorded in meeting minutes. During the inspection they amended the meeting standard agenda items to include significant event discussion.
- Significant event forms included brief information about learning outcomes. These were not reviewed to ensure learning was embedded and incidents had not been repeated.

Overview of safety systems and processes

The practice did not have defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One partner was the lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. We saw evidence that most staff had received safeguarding training. The safeguarding lead was trained to child safeguarding level three. The other partner told us they were trained to level two but we saw no evidence of this. Following the inspection we received evidence they had completed safeguarding children level two on 14 August 2017. In addition there was no evidence that the locum practice manager had received training. Although this was not held by the practice at the time of the inspection it was provided following the inspection.
- A notice in the waiting room 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).

The practice maintained appropriate standards of cleanliness and hygiene, although processes were not always robust.

- We observed the premises to be clean and tidy. There were cleaning schedules in place.
- One of the GP partners was the infection prevention and control (IPC) lead, although the practice manager and locum practice manager had day to day responsibility for IPC. We saw the most recent infection control audit had been carried out in February 2017 by the locum practice manager. Issues were highlighted around the lack of staff training around IPC and accurate staff immunisation records. An action plan was in place stating these actions should be completed by December 2017. The practice manager told us the locum practice manager had carried out a handwashing audit. However they could not find a record of this.
- We saw some evidence of IPC training for staff. However there was no evidence that the practice nurse, or the locum practice manager who had carried out the IPC audit, had been trained. Following the inspection the practice provided evidence that the locum practice manager had received infection control training.
- The practice manager told us privacy curtains, where used, were changed every year. We saw they had been replaced in April 2017. We were told the fabric screens were laundered every six months. Although they did not keep a record of this they told us they had a reminder on their telephone to do this each January and July.

Inadequate

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms were securely stored and there were systems to monitor their use. One partner told us no prescriptions were handwritten. However the other partner told us they did write some prescriptions and they kept some blank prescription pads at home that were not recorded.

We reviewed five personnel files and found appropriate recruitment checks had not always been undertaken prior to employment. Identity checks had been completed and DBS checks had been carried out appropriately. However, there were examples of evidence of conduct in previous roles not being appropriately sought, and some references were from employers that were not mentioned in the employees' work history. Evidence that the practice nurse had medical indemnity insurance had not been sought.

The practice manager told us they last used a locum GP in October 2016. They said they asked to see evidence of the checks required, but did not copy these.

Monitoring risks to patients

Procedures for assessing, monitoring and managing risks to patient and staff safety were not robust. .

- The practice manager told us the locum practice manager had responsibility for health and safety. There was no evidence they had received training for this role. They did not carry our formal regular health and safety checks.
- Four small fire extinguishers were held at the practice. One of these did not have an expiry date on it and the practice manager told us it had been given to them from a medicines company. The other three fire extinguishers had expired in 1997, 1999 and 2003. The practice manager told us they were not aware checks should be carried out on fire extinguishers.
- The practice manager told us they checked the fire alarms monthly but they could not find evidence of this. They told us they did not check escape routes. A fire evacuation had taken place as part of fire training carried out by the locum practice manager on a Saturday in November 2016. There was no record of the length of time taken to evacuate the premises. There was also no evidence the locum practice manager had received fire safety training.
- The practice manager had carried out a fire risk assessment in May 2017. We foundnone of the issues found during the inspection had been identified.
- We told the practice manager that a fire risk assessment must be completed as a matter of urgency and fire extinguishers must be present on the premises. Following the inspection we received evidence that new fire extinguishers had been delivered and wall mounted on 20 June 2017.. They also told us a private company had carried out a full fire risk assessment the weekend following our inspection, although evidence was not received.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had not had a legionella risk assessment carried out. Following the inspection the practice sent us a report from an external company. The company stated one half of the building had no risk of legionella. Water samples had been taken from the other half of the building, where the boiler and plumbing had not been replaced, and legionella had not been found. However we did not receive a risk assessment or details of any on-going checked that could be required.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. One of the GPs did not always attend their surgery at the agreed times.

Inadequate

Are services safe?

Arrangements to deal with emergencies and major incidents

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

- All staff received annual basic life support training.
- Emergency medicines were available in the treatment room and all staff knew of their location. However the fire door for the treatment room was propped open during the inspection. The emergency medicines were kept in a locked cupboard in the room, but the key was kept on top of the cupboard. This room was easily accessible to patients and was not in view of the reception desk.
- Medicines and vaccines were kept in a fridge in the treatment room. The fridge was not locked and the fire door to the room had been propped open. The practice manager told us the room was not being used by a clinician that day.
- All the medicines we checked were in date.
- The practice had a defibrillator available. There were no formal checks to make sure the defibrillator was ready for use; the practice manager told us they looked at the defibrillator daily to check the green light was on.
- There was oxygen available with adult and children's masks. The practice manager told us the oxygen was checked to make sure it was ready for use but this check was not recorded.

The practice had a business continuity plan for major incidents such as power failure or building damage. Under the risk 'loss of electricity' the plan stated 'use paper/ candles'. The practice manager said they were not aware of that being in the plan. The plan also stated there was an emergency box kept in the manager's room. The practice manager told us this did not exist. The plan included emergency contact numbers for staff. Following the inspection the practice provided evidence that the business continuity plan had been updated.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

- The practice discussed these guidelines in clinical meetings. Clinicians also attended clinical commissioning group (CCG) meetings where new guidelines were discussed. We saw evidence that changes were implemented following NICE guidelines being received.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available compared with the clinical commissioning group (CCG) and national average of 95%. Exception reporting for this was 6%, which was below the CCG average of 7% and the 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 2015-16 showed:

- Performance for diabetes related indicators was 90%. This was above the CCG average of 88% and the same as the national average. The exception reporting rate was 2% compared to the CCG average of 8% and the national average of 13%.
- Performance for mental health related indicators was 100%. This was above the CCG average of 92% and the national average of 93%. The exception reporting rate was 0% compared to the CCG average of 8% and the national average of 13%. The practice told us mental health teams often carried out the mental health reviews and dementia reviews were carried out during routine reviews on patients in nursing homes.

There was no evidence of quality improvement including clinical audit:

- Some audits had commenced in the last two years, but none of these were completed two cycle audits where the improvements made were implemented and monitored.
- We saw evidence that following an audit in diabetes care read coding had improved.
- The practice participated in an external audit scheme for patients with a new cancer diagnosis.

Effective staffing

We saw variable evidence that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had a basic induction programme for all newly appointed staff. This covered information about the practice.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line.
- There was a small practice team and reception staff had had appraisals with the practice manager. There had been no appraisal for the locum practice nurse who started work in November 2015, and no appraisal for the practice manager who also doubled as the locum GP.
- Staff confirmed they received training but not all of this was recorded. E-learning was available and some training, such as fire safety training, had been carried out in-house. However this was by a staff member where there was no evidence they were competent to carry out the training. Although the practice manager had requested that one of the partners supply them with evidence of their training, such as safeguarding children, this had not been undertaken. Following the

inspection the practice manager sent us further evidence of training. We saw evidence that one GP partner had completed a safeguarding children level two course in August 2017.

Coordinating patient care and information sharing

The full information needed to plan and deliver care and treatment was not completed in patient records.

- During the inspection we found risk assessments and patient profiling were not maintained by the lead clinician. For example, information about patients' outcomes was not used to make improvements and care for patients with long term conditions was largely opportunistic. Following the inspection the practice provided additional evidence and this showed that patients at risk of hospital admission had a care plan in place, and patients were routinely assessed after they had been in hospital, with care plans being updated when required.
- There was no formal recall system in place for patients, including patients with multiple conditions. GPs told us the care for patients with long term conditions was largely opportunistic and carried out by GPs not the practice nurse. Following the inspection the practice sent us evidence that they had completed the required number of annual reviews for patients with long term conditions. They told us that searches were completed and patients were invited for an annual review of their condition.
- The majority of patients had received a medicine review. However, this was difficult to monitor as not all medicine reviews were correctly coded in the system.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients. Palliative care meetings took place monthly and these were attended by a multi-disciplinary team (MDT). We saw that the palliative care register was updated after these meetings.

We saw that the practice had an avoiding unplanned hospital admission register and there were care plans in place for these patients. Care plans were updated following fortnightly meetings with the integrated neighbourhood MDT.

Consent to care and treatment

We saw that advice regarding consent was not always in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Care of patients under the age of 16 was not consistent. The practice website and practice leaflet clearly stated that patients under the age of 16 should be accompanied by an adult. Reception staff told us patients under the age of 16 were unable to make an appointment without a parent being present. However the practice manager told us they were not aware this guidance had been issued and we spoke to a GP who had a good understanding of Gillick competence. Gillick competence is a term used to decide whether a child under 16 years of age is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients requiring help with smoking cessation and weight management could receive advice from the healthcare assistant or could be referred to an external service.
- Patients requiring help with drug or alcohol dependency were referred to an external service.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 85%, which was comparable with the CCG average of 82% and the national average of 81%. The exception reporting rate for cervical screening was 13%, which was above the CCG and national average of 7%. The practice manager told us they gave telephone reminders to patients attending cervical screening and they thought this reduced the number of patients who did not attend.

The uptake for breast cancer screening in the three years to March 2016 was 60%, compared to the CCG average of 72% and the national average of 73%. The uptake for bowel cancer screening in the 30 months to March 2016 was 48%, compared to the CCG average of 56% and the national average of 58%. The practice told us they were currently looking at the number of patients who did not take up the offer of bowel cancer screening.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were usually comparable to the CCG and national averages. For example, rates for the vaccines given to under two year olds ranged from 88% to 93% and five year olds from 78% to 90%. The standard for these should be 90%. We saw evidence that these figures had improved for 2016-17.

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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice told us they invited patients for these checks by text message. Although they said they kept information about how many patients had attended this could not be found during the inspection. However, following the inspection they told us that they had completed 410 checks out of 493 eligible patients.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

The 45 patient Care Quality Commission comment cards we received were mainly positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with nine patients including two members of the patient participation group (PPG). They told us they were usually satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments included that the reception area was welcoming and there was good customer service.

Results from the national GP patient survey published in July 2017 showed patients felt they were treated with compassion, dignity and respect. The practice was usually in line with or below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 86% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 86%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 86%.
- 91% of patients said the nurse was good at listening to them compared to the CCG average of 92% and the national average of 91%.
- 85% of patients said the nurse gave them enough time compared to the CCG average of 92% and the national average of 92%.
- 92% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 96% and the national average of 95%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 78% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that clinicians usually explained treatment and medicines to them so they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.

Good

Are services caring?

- 87% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. Two of the GPs spoke Urdu and Hindi, so they were able to support some patients. Two receptionists were also multi-lingual.
- The Choose and Book service was used with patients. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice manager told us they looked at the Choose and Book data each week to monitor uptake. However we looked at records from February 2017 to the date of the inspection and 26 patients had not yet booked an appointment.

Patient and carer support to cope emotionally with care and treatment

Some patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. GPs referred patients to a local counselling service if required, and patients could also self-refer.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 63 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Some of this information was available in languages other than English. Annual carers' health checks were also carried out, with 54 being carried out during 2016-17.

Staff told us that if families had experienced bereavement, their usual GP contacted so they could offer support by telephone and arrange an appointment if required.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Thursday evening until 8pm for working patients who could not attend during normal opening hours.
- Patients could access appointments in the evening and during the weekend at a nearby hub provided by the GP Federation.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were monthly multi-disciplinary team palliative care meetings following which care plans were updated.
- Same day appointments were available for children under the age of 10 and those patients with medical problems that require same day access.
- Patients received text reminder prior to their appointments.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- The practice was accessible for patients in a wheelchair. There was a hearing loop available. Interpreters were available, mainly by telephone. Two GPs spoke Urdu and Hindi, and two reception staff were multi-lingual.
- There was a stair lift available for patients. However, ground floor consultation rooms were available.
- The practice was planning to make improvements to the building as it was in need of refurbishment. They were applying for some funding through the clinical commissioning group (CCG) but there were outstanding issues regarding funding from the partners. Although the practice was planning the improvements they told us there was no formal business plan in place.

Access to the service

The practice was open between 8am and 6.30pm on Monday, Tuesday, Wednesday and Friday and between 8am and 8pm on Thursday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. Although patients told us they could normally easily access appointments, the practice manager told us one partner had started to telephone patients to cancel their appointments once made. They were unable to explain why this happened.

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

- 73% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 81% and the national average of 76%.
- 86% of patients said they could get through easily to the practice by phone compared to the CCG average of 80% and the national average of 73%. However, NHS Choices and patient feedback gained during the inspection suggested it was difficult to get through on the telephone. The practice manager told they intended to increase the phone lines from two to four, but we were not shown any plans to confirm this.
- 74% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 85%.
- 97% of patients said their last appointment was convenient compared with the CCG average of 92% and the national average of 92%.
- 71% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 42% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%. We spoke with patients who said they had to wait a long time to be seen.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. However we saw that one partner sometimes arrived late or left part way though their surgery, which could affect waiting times. There was no plan in place to improve these issues.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system to assess:

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

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

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. However, this was not effective. Reception staff kept a log of verbal complaints. Learning points from these complaints were not documented. The practice manager told us that most patients made written complaints straight to NHS England, not the practice. We asked reception staff for their complaints leaflet and we were given a generic information sheet about how to complain giving details of NHS England. We asked if there was a practice specific leaflet and were given an information sheet that stated complaints could be made to the complaints manager at the practice.

The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. It stated the practice manager was responsible for investigating complaints. However, they told us complaints about a GP were given to the GP they were about to investigate and respond to. They told us they had asked one of the partners for copies of their responses but had only been provided with some of these responses on the day prior to the inspection.

We looked at the complaints that had been dealt with by the practice. These were not well managed and evidence was not kept that all had been investigated. Responses to patients did not usually include information about how patients could escalate their complaint if they were unhappy with the response. We saw no evidence of learning from complaints. For example, complaints about a named GP had been given to that GP to respond to and the issues, although repeated, did not have a plan in place to make sure the issues did not happen again.

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 did not have a clear vision to deliver high quality care and promote good outcomes for patients. There was no mission statement and no formal business plan.

Governance arrangements

The practice did not have an overarching governance framework to good quality care.

- There was a staffing structure and non-clinical staff were aware of their own roles and responsibilities. However, the two GPs did not communicate or work well together. This animosity caused communication issues for staff.
- Some practice specific policies were implemented and were available to all staff. However some of these had not been updated or reviewed. For example, the business continuity plan included incorrect instructions.
- An understanding of the performance of the practice was not maintained. The practice did not monitor or improve the quality and safety of the services provided. For example clinicians were unable to provide documentation to support the completion of medicine reviews for patients with long term condition.
- There was no programme of continuous clinical and internal audit to monitor quality and to make improvements.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were inconsistent. We saw an example of a significant event that had not been recorded. Although we were told significant events were discussed in meetings there was no record kept of the discussion. There was no formal review of significant events to ensure learning was embedded.
- We found complaints that were not investigated appropriately and had not been reviewed to show whether learning had occurred or practice changed as a result of any action taken.
- There were monthly clinical meetings at the practice but these did not address some of the difficulties between clinical staff.
- The practice did not have a policy for staff who were patients at the practice.
- We did not see a clear process to monitor which staff had undertaken training. The lead GP was only trained to a level two in safeguarding children, and not the required minimum of level three.
- The practice manager told us one partner had started to telephone patients to cancel their appointments once made. They were unable to explain why this had happened.
- The practice website contained some incorrect information in relation to staff. The practice manager told us it was their responsibility to inform the person who ran the website to make changes.

Leadership and culture

On the day of inspection the partners in the practice could not demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. There was an inconsistent understanding of how safe, high quality and compassionate care was carried out.

This caused issues between the two partners that at the time of the inspection which had not been resolved, having a negative impact on the performance of the practice, which was dysfunctional. These issues had been on-going for some time and the practice manager, who was also the locum GP, told us they thought them becoming the practice manager would help with the issues.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Although there was an awareness of the duty of candour we saw that when things went wrong patients and other people affected were not always informed. Although some written records were kept these were not well organised so it was difficult to see how issues such as complaints were being managed.

One partner took the lead at the practice and staff felt supported by the partner and practice manager. However, the second partner was less involved in all aspects of the practice, including taking responsibility for how it was run.

Are services well-led?

Inadequate

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings. Records of meetings were very brief.
- Staff told us they had the opportunity to raise any issues with the practice manager and felt confident and supported in doing so. We noted that issues relating to a clinician had been raised with the practice manager. However, these issues had not been resolved.

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

The practice had carried out a patient survey in April 2017. The practice manager told us this was in response to a previous notification of a Care Quality Commission inspection. There was no action plan put in place following the survey being carried out. The practice manager told us they had not considered a formal action plan but had made some changes. For example, they included some blanks in the GP appointment schedule, so they could catch up if they were running late. However, they did not formally consider the reasons surgeries ran late.

The practice had a patient participation group (PPG). The PPG had no formal remit and the two PPG members we spoke with told us it was led by the practice manager. The practice manager told us they increased the number of GP appointments following feedback from the PPG.

The practice manager told us that although they checked NHS Choices they did not respond to comments. They told us this was because they believed the comments to be wrong and it upset them to read them.

Continuous improvement

We saw no evidence of a focus on continuous learning and improvement within the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. In particular: There was no formal process or response to patients taking place.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: There were no safety checks and risk assessments carried out or updated. These include fire risk assessments, fire safety checks, defibrillator checks and a legionella risk assessment. The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: the firefighting equipment must be made available at all times. There was no proper and safe management of medicines. In particular: there was no system to monitor medicine reviews and the care of patients with long term conditions. No medication reviews for patients were taking place. Medicines were not stored securely.

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 There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Recording of significant events was not consistent and there was no evidence of learning from significant events. Training was not adequately monitored or recorded. Out of date information was on the practice website. Some documents, such as the business continuity plan, contained incorrect information. Action

This section is primarily information for the provider

Enforcement actions

plans were not put in place following surveys. The process for employing new staff, particularly around ensuring references matched employments histories, needed strengthening.