The Billesdon Surgery

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Good**
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 Billesdon Surgery on 17 September 2015. Overall the practice is rated as inadequate.

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

- The system for reporting, investigation and dissemination of learning from significant events was inconsistent and disjointed so safety was not always improved.
- Data showed patient outcomes were in line with the national average. Although some audits had been started, we saw limited evidence that audits were driving improvement in performance to improve patient outcomes.
- Systems and processes within the dispensary were not robust.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day due to the practice's daily open surgery.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- We found there were limited means of accessing information about how to complain.
- The practice had a number of policies and procedures to govern activity, but some were over five years old and there was no evidence they had been reviewed since.
- The practice had limited means of encouraging feedback from patients with a view to engaging patients in the delivery of the service and had not always acted on issues raised by staff.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example, the system in place for monitoring and reviewing patients on methotrexate was not adequate.

The areas where the provider must make improvements are:

Summary of findings

- Ensure there is a clear and consistent system for dealing with significant events and that staff are supported to raise incidents.
- Ensure the complaints system is accessible.

- Ensure there are formal governance arrangements in place and staff are aware how these operate, including having appropriate policies and guidance in place.
- Ensure there are mechanisms in place to seek feedback from staff and patients and this feedback is responded to.
  - Ensure there are effective systems in place for monitoring patients and the quality of care, including appropriate care plans being in place, the 'hypertension improvement plan'and 'methotrexate prescribing protocol' being implemented and adhered to and robust clinical audits being undertaken in the practice, including completed clinical audit or quality improvement cycles.
  - Ensure all staff are up to date with mandatory training.
  - Ensure appropriate fire safety arrangements in place, including regular fire drills and fire alarm testing and an up to date fire risk assessment in place.
  - Ensure there is a robust system in place for the management of emergency equipment and medicines.
- Ensure all staff receive annual appraisals.
- Ensure systems and processes in the dispensary are robust, including adequate leadership and that competencies of dispensary staff are checked appropriately.
- Ensure appropriate risk assessments are in place, for example,legionella and staff working alone at branch surgery.
- Ensure appropriate systems and processes are in place relating to infection control in line with national guidance, including actions from infection control audits being recorded and implemented.
- Ensure a statement of purpose is in place and submitted to the Care Quality Commision.

In addition the provider should:

- Ensure a comprehensive business continuity plan is in place.

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

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. There was insufficient information to enable us to understand and be assured about safety. Staff were not always encouraged to report incidents. The system for the reporting, investigation and dissemination of learning from significant events was disjointed and not robust so safety was not always improved. Patients were at risk of harm because systems and processes were either not in place or not well implemented in a way to keep them safe. Risks to patients were not always assessed, reviewed or well managed, such as risk assessments relating to legionella and fire. Not all clinical staff had current basic life support training.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services. Data showed patient outcomes were in line with the national average, with the exception of the indicators for blood pressure checks for patients with hypertension and diabetes. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed but we found a lack of care plans for patients identified as being at a higher risk of an unplanned hospital admission. Patients who had been prescribed Methotrexate were not being monitored in line with best practice. We saw limited evidence of any completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs with the exception of regular fire training. The basic life support certificate was out of date for a few staff. There was evidence of appraisals and personal development plans for most staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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 easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Requires improvement 

The practice is rated as requires improvement for providing responsive services. It reviewed the needs of its local population and provided a daily open surgery to enable patients to access same day appointments with the GP of their choice. The open surgery was also available for nurse and healthcare assistant appointments. Patients said they found it easy to get an appointment and that there was continuity of care, as appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was not easily accessible and one patient said they had found it difficult to raise a complaint. Themes and trends from complaints had not been identified and learning was not always shared with staff.

Are services well-led?

Inadequate 

The practice is rated as inadequate for being well-led. It had a vision and strategy outlined in the mission statement. Not all staff were clear about the vision and their responsibilities in relation to this. There was a documented leadership structure but staff did not always feel supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and some policies were not in place at the time of our inspection. There were limited systems in place to monitor and improve quality and identify risk. The practice had not proactively sought feedback from staff and patients, or acted on feedback received from staff. Staff had attended staff meetings. Not all staff had received an appraisal in the last year.

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 good for being caring, requiring improvement for being responsive and inadequate for providing a safe, and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. Care and treatment of older people did not always reflect current evidence-based practice, as some older people did not have a care plan where necessary. Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.

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 good for being caring, requiring improvement for being responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nursing staff had lead roles in chronic disease management and patients at a higher risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Not all these patients had received a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 good for being caring, requiring improvement for being responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours. We saw good examples of joint working with health visitors and school nurses.

Summary of findings

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 good for being caring, requiring improvement for being responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, 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, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 good for being caring, requiring improvement for being responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability. The practice held a weekly reserved appointment slot to accommodate patients who lived in a local care home.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

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 good for being caring, requiring improvement for being responsive and inadequate for providing a safe, effective and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

97% of people experiencing serious mental health problems or dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Patients experiencing poor mental health could be booked in with an in house therapist within a week or offered the support of the in-house mental health facilitator.

Summary of findings

What people who use the service say

The national patient survey results published on 1 July 2015 showed the practice was performing above local and national averages. There were 131 responses and a response rate of 51.6%.

- 94.9% find it easy to get through to this surgery by phone compared with a CCG average of 68.4% and a national average of 74.4%.
- 90.7% find the receptionists at this surgery helpful compared with a CCG average of 85.2% and a national average of 86.9%.
- 72.2% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 59.4% and a national average of 60.5%.
- 91.8% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 85.5% and a national average of 85.4%.
- 97.5% say the last appointment they got was convenient compared with a CCG average of 92.3% and a national average of 91.8%.
- 87.1% describe their experience of making an appointment as good compared with a CCG average of 72.4% and a national average of 73.8%.
- 55.4% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 63.6% and a national average of 65.2%.
- 66.1% feel they don't normally have to wait too long to be seen compared with a CCG average of 59% and a national average of 57.8%.

We received four comment cards which were all positive about the standard of care received. Comments reflected the practice staff being kind, helpful and patient and described an excellent standard of care.

Areas for improvement

Action the service MUST take to improve

- Ensure there is a clear and consistent system for dealing with significant events and that staff are supported to raise incidents.
- Ensure the complaints system is accessible.
- Ensure there are formal governance arrangements in place and staff are aware how these operate, including having appropriate policies and guidance in place.
- Ensure there are mechanisms in place to seek feedback from staff and patients and this feedback is responded to.
- Ensure there are effective systems in place for monitoring patients and the quality of care, including appropriate care plans being in place, the 'hypertension improvement plan' and 'methotrexate prescribing protocol' being implemented and adhered to and robust clinical audits being undertaken in the practice, including completed clinical audit or quality improvement cycles.
- Ensure all staff are up to date with mandatory training.
- Ensure appropriate fire safety arrangements in place, including regular fire drills and fire alarm testing and an up to date fire risk assessment in place.
- Ensure there is a robust system in place for the management of emergency equipment and medicines.
- Ensure all staff receive annual appraisals.
- Ensure systems and processes in the dispensary are robust, including adequate leadership and that competencies of dispensary staff are checked appropriately.
- Ensure appropriate risk assessments are in place, for example, legionella and staff working alone at branch surgery.
- Ensure appropriate systems and processes are in place relating to infection control in line with national guidance, including actions from infection control audits being recorded and implemented.

Summary of findings

- Ensure a statement of purpose is in place and submitted to the Care Quality Commission.

Action the service SHOULD take to improve

- Ensure a comprehensive business continuity plan is in place.

The Billesdon 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 and a further two CQC Inspectors.

Background to The Billesdon Surgery

Billesdon Surgery is a GP practice which provides a range of primary medical services to around 6,800 patients from a main surgery in the town of Billesdon in Leicestershire and a branch surgery in Bushby, Leicestershire. The practice's services are commissioned by East Leicestershire and Rutland Clinical Commissioning Group (CCG). The practice has a dispensary which dispenses medicines to 58% of patients registered with the practice.

The service is provided by three full time male GP partners, a part time female GP partner and a part time female salaried GP which provided a total of 34 GP sessions per week. There are also two part time practice nurses and a part time health care assistant. In the dispensary there are three part time dispensers. They are supported by a practice manager, assistant practice manager and reception and administration staff.

The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Local community health teams support the GPs in provision of maternity and health visitor services.

The practice has one location registered with the Care Quality Commission (CQC). The location we inspected was Billesdon Surgery, 4 Market Place, Billesdon, Leicester. LE7 9AJ

We also visited the branch surgery at Hill Court, Main Street, Bushby, Leicester. LE7 9NY.

The main surgery is in a two storey building with a car park which includes car parking space designated for use by people with a disability. All patient facilities were on the ground floor. The branch surgery was on the ground floor of a building which the practice rented from the East Mildand Housing Association. It also had parking at the front of the building.

We reviewed information from East Leicestershire and Rutland CCG and Public Health England which showed that the practice population had much lower deprivation levels compared to the average for practices in England.

The main surgery is open between 8.30am and 6.00pm Monday to Friday with open surgery from 8.30am to 10.00am and pre booked appointments from 2.30pm to 6pm. The branch surgery is open between 8.30am to 11am Monday to Thursday and 10.00am to 11.10am on Friday. It also opens between 4.00pm to 6.00pm on Mondays and 4.30pm to 6pm on Fridays. Between 8.00am and 8.30am and 6.00pm and 6.30pm Monday to Friday an emergency doctor is available.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided to Leicester City, Leicestershire and Rutland by Central Nottinghamshire Clinical Services.

The practice did not have a statement of purpose available which is a requirement under regulation 12 of the CQC (Registration) Regulations 2009.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This 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.

The provider was previously inspected on 29 October 2013 and met the standards inspected at that time.

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.

How we carried out this inspection

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed information from East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG), NHS England (NHSE), Public Health England (PHE) and NHS Choices.

We carried out an announced inspection on 17 September 2015.

During our visit we spoke with a range of staff including GPs, nurses, dispensers, the practice manager and reception and administration staff. We also spoke with three patients who used the service. We observed interactions between staff and patients and talked with carers and family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice did not have in place a sufficiently clear, consistent or robust system for recording, analysing and acting upon significant events. There was no policy in place relating to significant events and no log of significant events. Records of significant events were kept in three different folders, depending on which area of the practice they related to and there were two different reporting forms in use.

Some significant events were discussed at dispensary meetings with dispensary staff, some at clinical meetings with GPs and nurses and some at quarterly significant events meetings with all staff. Examples were seen of incidents that has been discussed at dispensary meetings that all GPs should have been made aware of but we did not see any evidence of this in minutes of meetings we looked at. The investigation and dissemination of learning from significant events was not robust.

During our inspection, we requested details of annual reviews of significant events. We were told that these had not been carried out and that there had been no exercise had been undertaken to identify any themes or trends. We were told that a meeting scheduled for 29 September 2015 would include reference to this.

Some members of staff expressed concerns that they did not always feel able to raise concerns. One staff member described trying to raise a significant event regarding a missed patient death notification. This was only discussed at a significant events meeting because a member of staff raised it again at the meeting. There was no significant event form available relating to the incident and no record of any investigation. The only record relating to this event was within the minutes of the significant events meeting of 20 May 2015. The proposed action recorded was not robust.

Prescribing errors were not reliably recorded as significant events. For example a medication error had been raised as an issue with the Care Quality Commission prior to our inspection. The records we looked at during our inspection showed that an email had been sent by a GP to the practice manager regarding this but no significant event form had been completed. Dispensary staff were unaware of significant events that had occurred in the dispensary.

Following such events, where they were identified, insufficient action was being taken to analyse the cause of events or to put in place measures to prevent its reoccurrence.

Following our inspection the practice provided us with a 'Significant events meetings policy' document the purpose of which was to provide an overarching framework to ensure that all incidents and complaints are dealt with promptly and appropriately.This should enable the practice to maximize the opportunity for fully shared input and learning across the whole Primary Health Care Team.This included a single process and more frequent meetings.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. We saw evidence that NICE guidance had been discussed at a clinical meeting. We were also told that national patient safety alerts were discussed at clinical meetings and were also received by the dispensary. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The practice did not have a policy for the safeguarding of vulnerable adults in place, however following our inspection they provided a policy. There was a lead GP for safeguarding. The GPs attended safeguarding meetings every three months and provided reports where necessary for other agencies. We spoke with the health visitor who was based at the surgery and they confirmed that they attended the safeguarding meetings and felt very supported by the GPs at the practice. They gave examples of effective joint working with the practice. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- Nursing staff and reception staff acted as chaperones when required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may

have contact with children or adults who may be vulnerable). The practice had a chaperone policy in place however this was not practice specific and was not dated.

- There were limited procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety risk assessment dated December 2014 which related to different rooms and patient areas of the premises and included the location, hazards, actions anddate completed. The practice did not have in place a five year fixed electrical wire test or a gas safety certificate. Following our inspection the practice provided evidence that the gas and electrical safety inpsections had been scheduled.
- The practice did not have an up to date fire risk assessment, the last one having been undertaken in 2007. Regular fire alarm system checks or fire drills had not taken place. There were only seven checks of the fire alarm system since 2013. Fire equipment had been checked in the last 12 months. There was a fire policy in place. However this was not dated and related to the main surgery only. There were no named fire wardens and annual fire safety training for staff did not take place. Following our inspection the practice provided a 'fire risk assessments policy document' the purpose of which was to ensure that a fire risk assessment was carried out annually. They also provided a 'fire alarm test and fire drill policy', the purpose of which was to ensure that regular fire alarm tests and fire drills took place. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had undertaken legionella risk assessments for both the branch and main surgery in June 2014. The main surgery had been rated as a medium risk. There was a number of actions identified as a result of this and we saw limited evidence that these had been implemented.For example there were no records of the checking of water temperatures on a monthly basis, which had been a required action. Following our inspection the practice provided a legionella policy and documentation indicating they had started to record water temperatures at both surgeries after our inspection.
- The practice had an infection control policy in place which had been approved in July 2015. This named the infection control lead as the practice manager. However we were told during our inspection that the assistant practice manager was the infection control lead. We observed the premises to be clean and tidy. In house infection control training took place annually for all staff. We found that full infection control audits had not been undertaken. We were shown a 'quarterly infection control audit' for the main and branch surgery from July 2015 but these consisted of a statement saying an audit had been carried out and with some points for action. Following our inspection we were provided with copies of infection control audits undertaken on 22 September 2015 at both surgeries.
- COSHH information which relatedto cleaning products was available to ensure their safe use. However we found on the day of the inspection that the practice did not have a system in place to ensure they were up to date. Some had not been updated since 2004. Following our inspection the practice manager provided a COSHH sheet review policy and informed us that they would ensure that all information was up to date.
- We checked sharps bins at Billesdon and the branch surgery. We found six sharps bins were not correctly labelled with a date and signature in line with the all information on the sharps box label must be completed in full. We were told that sharps bins were changed by the cleaner. We saw there were three external clinical waste bins. These were not locked and were not in a locked compound in line with national guidance. Following our inspection the practice provided us with a standard operating procedure called 'making up sharps bins' which identified the need to sign and date sharps bins when they were assembled.
- We found thatdisposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. However at the main surgery we saw two curtains which had not been changed since April and August 2014 and at the branch they had not been changed sinceJune and July 2014. National guidance recommends that disposable curtains are changed every six months.
- The practice had a lead for medicines management. The dispensary had documents which they referred to as Standard Operating Procedures (SOP's). These covered all aspects of work undertaken in the dispensary. The

SOP's should consist of step-by-step information on how to execute a task and an existing SOP should be modified and updated when appropriate. All staff involved in the procedures had signed a front sheet to say they had read and understood the SOP and agree to act in accordance with its requirements.

- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. The practice had submitted their yearly written evidence of compliance on 17 April 2015. We found that this written evidence did not reflect what we found on the day of the inspection.
- We found that the SOP's did not fully reflect good professional practice or the procedures that were actually performed in the dispensary. The SOPs did not indicate the level of competency expected for each function performed by dispensers. Most of the SOPs had not been reviewed and updated in the last 12 months. No reference had been made to any dispensing procedures which had been amended. There was no written audit trail of amendments to SOPs. On the written evidence submitted for DSQS the practice had recorded that this had been completed.
- Records showed that all members of staff involved in the dispensing process had received appropriate training. However the practice did not have records to demonstrate that their competence was checked regularly. The practice could not therefore assure themselves that the dispensary staff were competent to perform the tasks and roles assigned to them. We spoke with dispensary staff who confirmed that they had not had their competence formally checked since obtaining their qualifications. On the written evidence submitted for DSQS the practice had recorded that this had been completed. Following our inspection we were told by the practice that dispensing competency reviews would be undertaken on all dispensing staff.
- Following our inspection we were informed by the practice that an audit of dispensing procedures had been commissioned by a consultant pharmacist.
- The dispensary accepted back unwanted medicines from patients. NHS England's Area Team made arrangements for a waste contractor to collect the medicines from the dispensary at regular intervals. We found that the dispensary had secure containers to keep the unwanted medicines in but there was no records kept of the medicines received by the practice.
- The practice held a minimal stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were appropriate arrangements in place for the destruction of controlled drugs.
- We checked the medicine refrigerator in the dispensary. We found that it was a domestic fridge with no thermometer to measure the temperature. The practice used a policy written by a local secondary care trust called 'maintaining cold chain of medicines policy'. It stated that ordinary domestic refrigerators must not be used for the day to day storage of medicines. We spoke with the management team and received confirmation the next day that the practice had purchased a new refrigerator suitable for the storage of medicines.
- We checked medicines stored in the treatment room and the medicine refrigerators at both the main surgery and the branch surgery and found they were stored securely and were only accessible to authorised staff. Two members of staff checked the refrigerators at both locations.
- We looked at the refrigerator temperature records for both locations and found that they had not always been recorded daily in line with national guidance to ensure they remained within specified limits. Therefore the practice could not be assured that the integrity and quality of the medicines were not compromised. Following our inspection the practice provided us with a standard operating procedure for checking the temperature of practice refrigerators. However this did not specify that minimum and maximum temperatures should be recorded or that the fridge should be reset. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

Inadequate

Are services safe?

- On the day of the inspection we saw practice staff using the dispensary door as acut through to kitchen area and reception. There was a more suitable door off the main corridor which staff could use. We concluded that this could be a patient safety risk as dispensers could be distracted by the interruptions while dispensing medicines. We were informed by the practice following our inspection that all staff had been advised not to use the dispensary as a cut through any longer.
- All prescriptions were reviewed and signed by a GP before they were given to the patient. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed staff told us they would be returned to the GP for signature.
- Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the six files we reviewed showed that 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.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- The practice had some arrangements in place to deal with emergencies. Staff had received basic life support training but we found this was out of date for three GPs and the nursing staff. Emergency equipment was available at both the main and branch surgery. This included access to oxygen and a defibrillator used for cardiac emergencies.
- Staff had completed monthly checks of the equipment at the branch surgery but the checks at the main surgery were irregular, for example monthly and then three monthly. The practice did not have a policy for the checking of emergency equipment and medicines. However following our inspection the practice provided a relevant policy which they were implementing.
- Emergency medicines were easily accessible to staff in a secure area of the practice and the branch surgery and staff we spoke with knew of their location. All the medicines we checked were in date and fit for use.

The practice did not have a comprehensive business continuity plan in place to deal with emergencies that may impact on the daily operation of the practice.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 94.5% of the total number of points available which was in line with the national average of 94.2%. The practice was an outlier for the QOF targets relating to blood pressure checks for patients with diabetes and hypertension. Data from 2013-14 showed;

- Performance for diabetes related indicators was generally lower than the national average, particularly the indicator for the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less. The practice scored 60.67% compared to the national average of 78.53%
- The percentage of patients with hypertension having regular blood pressure tests was

  59.14% which was much worse than the national average of 83.11%. There was no comparable data for 2014-15 available at the time of our inspection.
- Performance for mental health related and hypertension indicators was variable with some figures higher and some much lower than national averages. For example ;

91.67% of patients with a mental health condition had a comprehensive agreed care plan

documented in their record in the last 12 months compared to the national average of 86.04%.

88.65% of patients with physical and/or mental health conditions had their smoking status

recorded in the last 12 months compared to the national average of 95.28%.

- We looked at the data for the year 2014-15 which the practice provided us with and found that the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 49% against a target of 78%. This was lower than the previous year.
- The data for the percentage of patients with hypertension whose last blood pressure reading was 150/90 mmHg or less was 78% against a target of 80 % which was an improvement on the previous year.

We spoke with one of the GP partners who told us they had been tasked with looking at this area to find out why the figures were so low. They had found a trend towards not having blood pressures recorded or not actioning the required level to optimise care and for the prevention of secondary factors or conditions. There were no designated long term conditions clinics at the time of our inspection. Following our inspection the practice formulated and provided us with a thorough 'hypertension improvement plan' and 'hypertension protocol', with target dates for action. We were also provided with reports on asthma and COPD dated July 2015 which the practice had commissioned externally. There was no evidence of any dissemination or associated action plans to effect the recommendations but we were told the findings were due to be discussed at the next clinical meeting.

We found failings in relation to the monitoring of high risk drug prescribing. For example, in relation to patients who had been prescribed methotrexate, there were no shared care agreements in place on either of the two sets of patient notes seen on the day. No process was in place to check these and no review dates recorded. An audit carried out in March 2015 highlighted patients had not been monitored in line with best practice. Despite two sets of meeting minutes identifying the need for this to be addressed, no action had been taken to do so. Following our inspection we were provided with a 'methotrexate prescribing protocol' which was documented as having

Inadequate

Are services effective?

(for example, treatment is effective)

been updated on 21 September 2015.We did not see any evidence of dissemination or discussion around the implementation of the protocol with clinicians and dispensing staff.

The practice did not have a robust system in place for carrying out full cycle clinical audits. Audits we were shown appeared to be solely data gathering, lacked detail and were carried out either reactively or requested by the CCG , for example in relation to medicines management. There was no system or process in place to identify areas for quality improvement in patient care and outcomes against defined criteria with subsequent evidence of implementation of changes to facilitate this and regular review of these outcomes. For example we looked at an audit of minor surgery which looked at the number of excisions carried out and the number sent for histological diagnosis. The conclusion of this was that all samples should be sent for histological diagnosis. There was no evidence of a plan for this or that it had been discussed in the practice.

Effective staffing

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

- The learning needs of staff were identified through a system of appraisals, reviews of practice development needs and staff identifying their own needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. Nurses did not receive clinical supervision but felt supported by the GPs. There was facilitation and support for the revalidation of doctors. Most staff had received an appraisal within the last 12 months, but some staff had not had one since 2013. We spoke with staff within the dispensary and not all members of staff had received an appraisal on a yearly basis.
- Staff received training that included: safeguarding, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. However some training for basic life support was out of date and there was no fire safety training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services, for example when people were referred to other services. However we found that a member of the administration staff were responsible for using the scanning coding process on the practice's electronic records system. On the days when they were not at work this was carried out by other non clinical members of staff.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings relating to palliative care took place on a monthly basis and were attended by the district nurse and the Macmillan nurse when available.

However when we looked at records of three of these patients we found that two had care plans and special notes in place but the third did not have a care plan in place. This was in spite of the fact they had been identified as being a patient within the highest 2% of the practice population at highest risk of an unplanned admission to hospital. They should therefore have had a care plan in place.

We also found in regard to this group of patients at highest risk of an unplanned admission that one GP partner did not know if there was a system in place for them, including follow-up or review meetings and had not been party to any recent meetings for this group of patients. There were no recent meeting minutes which included risk avoidance.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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. We saw evidence of 'Do not attempt cardio-pulmonary resuscitation' (DNAR) orders in place. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's

Inadequate

Are services effective?

(for example, treatment is effective)

mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Some patients who may have been in need of extra support had been identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet and alcohol cessation. Patients were then signposted to the relevant service. This was generally opportunistic as there were no specific long term conditions clinics operating, although one of the GPs we spoke with told us this may happen in the future.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81.08%, which was comparable to national average of 81.88%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, from the data available childhood immunisation rates for the vaccinations given to under two year olds were 97.9% and five year olds from 94% to 97%. Flu vaccination rates for the over 65s were 75.51%, and at risk groups 57%. These were above national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff were aware that when required they could offer patients a private room to discuss their needs.

The four patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a flexible service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was generally in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 88.2% said the GP was good at listening to them compared to the CCG average of 91.2% and national average of 88.6%.
- 89.5% said the GP gave them enough time compared to the CCG average of 89% and national average of 86.8%.
- 95.8% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.6% and national average of 95.3%
- 88.9% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87.4% and national average of 85.1%.
- 97.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90.4%.
- 90.7% said they found the receptionists at the practice helpful compared to the CCG average of 85.2% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and 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 on the comment cards we received was also positive and aligned with these views.

Results from the national patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were above local and national averages for GPs and well above local and national averages for nurses. For example:

- 88.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86.3%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82.1% and national average of 81.5%
- 97.7% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 88.9% and national average of 89.7%.
- 90.3% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82.6% and national average of 84.9%

We spoke with one of the GPs about the requirement for translation services. They told us they were not used as those patients whose first language was not English generally brought a relative with them to translate.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. There was also information available via links on the practice website.

Good

Are services caring?

The practice had a carers register which we were told included 49 patients. Information was available for carers on the practice website to enable them to understand the various avenues of support available to them.

Staff told us that if families had suffered bereavement, a letter of condolence was sent to the. family with the offer of help or support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered a daily open surgery from 8.30am until 10am.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or patients who would benefit from these.
- Urgent access appointments were available.
- There were disabled facilities at both surgeries.
- All patient services were on the ground floor for greater accessibility.

Access to the service

The main surgery was open between 08.30am and 6.00pm Monday to Friday with an open surgery from 08.30am to 10.00am and pre booked appointments from 11.00am to 12.15pm and 3.00pm to 6pm. The branch surgery was open between 8.30am to 11am from Monday to Thursday and 10.00am to 11.10am on Friday. It also opened between 4.00pm to 6.00pm on Mondays and 4.30pm to 6pm on Fridays. Between 8.00am and 8.30am and 6.00pm and 6.30pm Monday to Friday an emergency doctor was available. The practice did not offer extended opening hours. The open surgery meant that In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them. Patients we spoke with on the day of our inspection or those who completed comments cards were very positive about and appreciated the benefits of an open surgery but some commented on the fact that it could mean waiting two hours to be seen. Others commented that they felt the wait for a routine appointment was too long.

These positive comments were reflected in the results from the national patient survey which showed that patient's satisfaction with how they could access care and treatment was above local and national averages other than for the waiting time after appointment time. People we spoke to on the day were able to get appointments when they needed them. For example:

- 75.5% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75.7%.
- 94.9% patients said they could get through easily to the surgery by phone compared to the CCG average of 68.4% and national average of 74.4%.
- 87.1% patients described their experience of making an appointment as good compared to the CCG average of 72.4% and national average of 73.8%.
- 55.4% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63.6% and national average of 65.2%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice had a complaints policy in place which was generally in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. However the policy did not make reference to the timescales involved in raising a complaint or give details of advocacy support available to assist patients in raising a complaint.

There was a poster in the waiting room with information about the complaints system but staff we spoke with told us there was no information available to give to patients and there was no complaints information available on the practice website. We spoke with one patient who told us they had once tried to make a complaint and found there was insufficient information to guide patients regarding raising a complaint. They described trying to make a complaint to the practice manager but had felt they were not interested.

We looked at four complaints received in the last 12 months and found these had been dealt with in a timely way.

We saw a summary of these complaints with actions or learning identified and the date they were due to be discussed at a practice meeting. A written response was not always given and themes or trends had not been identified. However the complaints summary stated the summary would be for discussion at a clinical meeting at the end of September and the practice manager told us themes would be identified then.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was displayed on the practice website. Some of their aims were to provide effective, efficient and safe healthcare services for patients and to treat patients fairly and equally; with dignity and respect.

Governance arrangements

The practice had a limited governance framework in place to support the delivery of the strategy and good quality care. We found that :

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Some policies and procedures to govern the practice were in place, some were either not practice specific, undated or had not been reviewed. At the time of our inspection there were no policies available for safeguarding vulnerable adults, legionella, fire safety or significant events, however these were provided following our visit. Some nurse protocols we looked at were dated 2009, others were not dated and did not appear to have been reviewed, for example the MRSA protocol which had not been reviewed despite there having been a significant event relating to MRSA.
- The practice did not have in place a programme of continuous clinical and internal audit in order to monitor quality and make improvements.
- There were limited arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was not a structured or robust approach for dealing with dealing with significant events.
- Issues had been documented in meeting minutes but not been actioned. For example, a health care assistant had requested first aid or basic life support training after having to carry out a clinic alone at the branch surgery in October 2014. The training was not undertaken until July 2015 despite it being recorded twice in clinical meeting minutes that a GP was going to deliver some first aid training. Similarly it had been identified in March 2015 that patients on Methotrexate were not being monitored in line with best practice. Despite two sets of meeting minutes identifying the need for this to be addressed, no action had been taken to do so.
- In the dispensary SOPs were out of date and did not include staff competencies. Staff competencies had not been formally checked on an annual basis.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The partners were visible in the practice and staff told us that they were approachable. However we found there was a lack of leadership in the dispensary and no dispensary manager in place.

Staff told us that regular team meetings were held. However dispensary meetings were held when considered necessary and staff told us that the agenda for the dispensary meetings was not available until just before the meeting started. A number of staff. across all staff groups we spoke with. told us that there was not always an open culture within the practice. They told us that they did not feel supported to raise issues at team meetings and had been discouraged from raising significant events.

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

The practice had limited means of encouraging feedback from patients with a view to engaging patients in the delivery of the service. The practice told us they had a virtual patient participation group (PPG) in place. The means of accessing this was by signing up to a social media network via a link on the practice website. There were just under 100 members of this group.

The practice had posted four online questionnaires over the last three years, asking members which areas could be improved, opinions on telephone consultations and face to face appointments, how likely members were to recommend the practice and opinions on the system for accessing GP appointments. The maximum number of responses to any of these was 15 and only five to the most recent questionnaire which was in February 2015. This was therefore not representative of the practice population and was limited to those who used the internet and we did not see any evidence of improvements as a result of patient consultation or feedback. The 2014 results from the NHS

Are services well-led?

Inadequate

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

Friends and Family Test were available on the practice website which reflected that 100% of patients who had responded were either extremely likely or likely to recommend the practice to friends or family.

The practice had gathered feedback from staff through staff meetings and appraisals but not always acted on it. Some staff told us there were times when they did not feel supported. Communication issues had been raised by a number of staff at appraisals but they had not received any feedback or seen any improvement as a result. Most staff had received an annual appraisal but some staff had not had an appraisal since 2013.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures 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 Care and treatment was not being provided in a safe way for service users. The provider was not assessing the risks to the health and safety of service users of receiving the care or treatment or doing all that is reasonably practicable to mitigate any such risks. The provider was not ensuring that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The provider had not ensured that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. The provider did not have appropriate arrangements in place for the proper and safe management of medicines. There was no robust or adequate system in place for monitoring and review of patients prescribed methotrexate. Learning from significant events was not shared with relevant staff. Not all staff were up to date with mandatory training. Fire drills had not been carried out regularly and fire alarm testing was inconsistent. There was no robust system in place for the management of emergency equipment and medicines. These matters are in breach of regulation 12(1), 12(2)(a)(b)(c)(d)(e)(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 The provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. The systems and processes in place did not enable the provider to identify where quality and safety were being compromised and had not always responded appropriately and without delay. Learning from significant events was not shared with relevant staff. Not all policies were available as they were in the process of being reviewed. There was no system in place to ensure staff were aware of reviewed policies. There were no systems in place to ensure staff received annual appraisals. There was not an adequate system in place for carrying out clinical audits. Prescription pads were not handled in accordance with national guidance. The practice Disaster Recovery Plan had not been reviewed since 2011. There was not a robust system in place to gain patient feedback. This is in breach of Regulation 17 (1) (2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The registered person had not provided the Commission with a statement of purpose containing information listed in Schedule 3. This is in breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009.