Dr Binoy Kumar

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive, follow up inspection on 19 August 2015. This was undertaken following an inspection on 17 February 2015 when compliance actions (now known as requirement notices) were issued. This was due to shortfalls identified in care and treatment and governance of the practice.

We found at the August 2015 inspection that there had been little improvement, with the practice still not meeting the required regulations of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At this inspection we found the practice to be inadequate in the safe, effective and well led domain and requires improvement for the caring and responsive domains.

Overall we have rated the practice Inadequate.

Our key findings were as follows:

- The maintaining of accurate and up to date records of clinical treatment, particularly medicines reviews, for patients was still not effective.
- The system to review policies and procedures had not improved and was still not efficient.
- There was still no central register of policies
- There was still no central register of training to demonstrate training which staff had undertaken or were due to complete.
- The GP had still not implemented a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy.
- There was no consent policy in the policy folder provided. We were not provided with an updated policy or any guidance that related to the taking of consent or in relation to the Mental Capacity Act 2005
- The recording and analysis of, and learning from any incident remained ad hoc, with little evidence of learning disseminated to staff.
- There was still little evidence that demonstrated the practice continually assessed, monitored and improved the quality and safety of the service provided.

Summary of findings

- The practice was clean and tidy
- Patients we spoke with said the GP and nurse explained treatments well
- Staff responded well to any safeguarding incident and were supported by effective safe guarding procedures

Importantly, the provider must:

- Maintain an accurate record of patient's care and treatment, particularly in relation to medication reviews
- Implement a more effective systematic approach to assessing and monitoring the quality of the service provided.
- Implement a clear written protocol or policy for responding to any medical emergency
- Implement a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy.
- Implement a more effective systematic approach to identifying and managing risks within the practice
- Implement a more systematic approach to record and evidence staff training

On the basis of the ratings given to this practice at this inspection, (and the concerns identified at two previous inspections in July 2014 and February 2015 which remain outstanding), I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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.

The practice had not sustained a systematic approach to documenting, investigating and evidencing learning from any significant event or incident. There was no documentary evidence to demonstrate that significant event analysis (SEA) was effectively shared with practice staff.

We were not provided with a risk register for the practice and there were no current risk assessments seen to identify and manage risks to patients and staff. There were no policies or procedures available for staff to follow in the event of any health care emergency, which could occur in the practice. This was raised at the inspection in July 2014 and again in February 2015, when a compliance action to make improvements (now requirement notice) was issued.

Although the practice had a comprehensive recruitment policy, this had not been fully implemented following the latest recruitment.

Staff had a good understanding of safeguarding and they were supported by appropriate guidance. Medicines were appropriately managed.

Are services effective?

Inadequate

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

There was no monitoring of outcomes of care and treatment by clinical audit. This was raised at the inspections in July 2014 and again in February 2015, when a compliance action (now requirement notice) to make improvements was issued. The GP had undertaken two case reviews but had not completed any two cycle audit to demonstrate the outcomes or effectiveness of care and treatment.

The practice did not have any written guidance in relation to the Mental Capacity Act (MCA) 2005 or how the staff would assess the best interests of patients. The GP had undertaken update training in the MCA 2005 but there was no documented evidence that this had been disseminated to the rest of the practice staff. Staff we spoke with stated they would refer any issues to the GP.

Summary of findings

Medication reviews for patients on multiple and frequently prescribed medicines had not been undertaken. These shortfalls were also found at the last inspection in February 2015, when a compliance action to make improvements (now requirement notice) was issued.

Although staff appraisals had been completed, these mainly consisted of staff self-appraisal with no evidence of performance monitoring, identification of personal or professional development.

The practice did not maintain a record of completed training by staff or a matrix of training to be undertaken. This was raised at the last inspection in February 2015

Are services caring?

Requires improvement

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

The two patients we spoke with during the inspection were positive about their experiences at the surgery. One patient told us she felt the practice had improved in the last two years, when they felt there had been some issues. They were complimentary about the GP and all the staff, who they stated were professional, yet friendly in their approach and always willing to help.

Information for patients about the services was available either in the surgery waiting room or via the practice website and was easy to understand.

We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Overall in the NHS England- GP Patient Survey published on 4 July 2015 the practice satisfaction results were lower than the previous year and we noted there were 435 survey forms distributed for the practice and 82 forms were returned. The practice therefore had a relatively low rate of 18.9%.

Are services responsive to people's needs?

Requires improvement

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

There was no documented evidence that the practice had effectively assessed the needs of its patient population or had engaged with the local Clinical Commissioning Group to secure service improvements to meet patient needs.

We were told by the practice they were providing services for patients who were seeking asylum in this country. However there was no explanation of any additional support provided for these patients.

Summary of findings

An extended surgery was held each Monday until 7pm for those patients who worked. Emergency appointment times were made available at fixed times in the morning and late afternoon.

There was a complaints policy in place. There had been no documented complaints since the last inspection in February.

Are services well-led?

Inadequate

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

There was no clear strategy or vision to assist staff to deliver future care and treatment. There was little improvement in the governance arrangements of the practice. There was no documentary evidence that the practice clinical governance policy was implemented effectively. This was raised at the inspection in February 2015.

There was no systematic programme of clinical audit to evaluate care and treatment within the practice. This was raised at the inspection in July 2014 and again in February 2015, when a compliance action to make improvements (now requirement notice) was issued.

There was no systematic approach to identifying and monitoring risks. This was also raised at the inspection in July 2014 and again in February 2015, when a compliance action to make improvements (now requirement notice) was issued.

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

This provider is rated as inadequate for providing safe, effective and well-led services. It is also rated as requires improvement for providing caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

As this was a single handed practice all patients were treated by the same GP. We saw that home visits were made to housebound elderly patients when requested.

Quality Outcomes Framework (QOF) data indicated that the uptake of the shingles vaccination for patients over 65 years, 85% was better than the national average of 73%.

The percentage of older patients who had received influenza immunisations was comparable at 83.9% with the local Clinical Commissioning Group (CCG) of 81.4% and the national average of 81.6%

People with long term conditions

Inadequate

This provider is rated as inadequate for providing safe, effective and well-led services. It is also rated as requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The GP led on the services for all long term conditions, such as diabetes, chronic obstructive pulmonary disease (COPD) and chronic heart disease. Input for the treatment of asthma was provided by the practice nurse. Care plans were in place for this population group and the practice and the practice manager explained that reviews were undertaken to avoid unplanned hospital admissions.

Quality Outcomes Framework (QOF) data indicated that the uptake of the influenza vaccination for patients identified as high risk due to other long term or medical conditions was 69.56% compared with the national average of 52.29%

Families, children and young people

Inadequate

This provider is rated as inadequate for providing safe, effective and well-led services. It is also rated as requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

The uptake of childhood immunisations and vaccinations for children 0 – 24 months remained good. Dedicated baby clinics and immunisation sessions ensured a sustained uptake. The practice had improved on the uptake of measles, mumps and rubella (MMR) immunisation at 93.9% compared with the CCG average of 86%. However the practice was still slightly below the CCG average of 91.9% for the immunisation uptake for five year olds, at 84.8%

Information in regards to sexual health for young people was available and the female practice nurse led on the cervical smear programme.

Working age people (including those recently retired and students)

Inadequate

This provider is rated as inadequate for providing safe, effective and well-led services. It is also rated as requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

A range of health promotion and screening which reflected the needs for this age group was available.

The National GP survey told us that 72.5 % of patients were satisfied with the practice's opening hours compared to the CCG average of 72.6 % and national average of 75.7%.

There was extended opening until 7pm each Monday evening to give some flexibility in appointments times for those patients who worked

People whose circumstances may make them vulnerable

Inadequate

This provider is rated as inadequate for providing safe, effective and well-led services. It is also rated as requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

We were told by the practice they were providing services for patients who were seeking asylum in this country. However there was no explanation of any additional support provided for these patients.

The practice continued to maintain a register of those people whose circumstances made them vulnerable. This included patients with learning disabilities. Checks were made each morning by the practice manager to ensure that none of the patients on the register

Summary of findings

had attended the out of hours service or accident and emergency. If patients had attended these services they were contacted to ensure they did not need to be seen by the GP. The practice told us they offered longer appointment times for this group of patients.

People experiencing poor mental health (including people with dementia)

Inadequate

This provider is rated as inadequate for providing safe, effective and well-led services. It is also rated as requires improvement for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice told us they continued to work with multidisciplinary community teams in the management of people experiencing poor mental health. there was no documented evidence of this provided. Data from the most recent QOF results indicated that the percentage of patients diagnosed with dementia, whose care has been reviewed in a face-to-face consultation, in the preceding 12 months was 75%, slightly below the CCG average of 78.3% and the national average of 77.9%

Summary of findings

What people who use the service say

We spoke with two patients on the day of the inspection who were waiting for appointments at the baby clinic, with their children. Both patients said that they were happy with the service provided by the practice. Both said that the practice was good at ensuring that children and babies were seen the same day when requesting appointments. Each felt that the GP and practice nurse explained treatments well and that they did not feel rushed during any consultation.

The NHS England- GP Patient Survey published on 4 July 2015 told us, of the respondents:

- 67.6% said the GP was good at treating them with care and concern – CCG average 85.4% National average 85.1%
- 74.6% said the GP they saw or spoke to was good at giving them enough time – CCG average 87%, National average 86.8%
- 71.4% said the GP they saw or spoke to was good at listening to them - CCG average 88.3%, National average 88.6%
- 63.3% said the GP they saw or spoke to was good at involving them in decisions about their care - CCG average 82.6%, National average 81.5%
- 87.7% said they had confidence and trust in the GP they saw or spoke to - CCG average 94.6%, National average 95.3%
- 89.3% said the nurse they saw or spoke to was good at giving them enough time- CCG average 92.2%, National average 91.9%
- 84.3% said the nurse they saw or spoke to was good at listening to them - CCG average 91%, National average 91%
- 84.4% said the nurse they saw or spoke to was good at treating them with care and concern - CCG average 90.4%, National average 90.4%
- 68.7% of respondents described their overall experience of this surgery as good – this result was less than the previous year's survey of 75% and below the current CCG average of 84.8% and National average of 85.2%

We noted there were 435 survey forms distributed for the practice and 82 forms were returned. The practice therefore had a relatively low rate of 18.9%.

Areas for improvement

Action the service MUST take to improve

- Maintain an accurate record of patient's care and treatment, particularly in relation to medication reviews
- Implement a more effective systematic approach to assessing and monitoring the quality of the service provided.
- Implement a clear written protocol or policy for responding to any medical emergency.
- Implement a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy.
- Implement a more effective systematic approach to identifying and managing risks within the practice.
- Implement a more systematic approach to record and evidence staff training.

Dr Binoy Kumar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP Specialist Advisor and an additional CQC inspector

Background to Dr Binoy Kumar

Dr Binoy Kumar (the provider), also known as St Pauls Surgery, is a single handed GP who provides primary medical services under a General Medical Services (GMS) contract, with NHS England.

The practice provides care under directed enhanced services for several areas of care including;

childhood immunisation, shingles immunisation, influenza immunisation, extended hours and facilitating early diagnosis of dementia. Enhanced Services are services which require an enhanced level of service provision above what is required under core GMS contracts.

The practice is part of the Greater Preston Clinical Commissioning Group (CCG) and has 2068 registered patients.

The practice population of 65 years and above is lower at 9.4%, compared with the national average of 16.9% and has 4.7% of patients over 75 years compared with 7.7 % national average. The practice also has a slightly higher than average proportion of working age patients of 63.6% compared with 60.7% national average. The practice has a high percentage of patients for whom English is not their first language and an increasing number of patients from Eastern Europe.

The surgery is located close to Preston city centre and information published by Public Health England, rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice opens from Monday to Friday from 9am until 6pm with GP appointments starting after 10 am each day. There is extended opening until 7pm each Monday evening. The practice is closed on a Thursday afternoon. When the practice is closed patients are advised to contact NHS 111. The out of hours service is provided by Preston Primary Care Centre, based at the local NHS hospital.

The practice staff includes; a GP, a practice nurse, one practice manager, two reception staff and a secretary. The practice nurse works eight hours per week split over two days; Tuesday afternoon and Wednesday morning. Patients requiring nursing treatments outside these times are referred to the district nursing service.

The practice uses the same locum GP, when required to cover leave or sickness, for continuity of care and support for their patients. Other services run by the practice include a weekly baby clinic for childhood development checks and a fortnightly immunisation clinic. Weekly ante-natal clinics are managed by the community midwives and a podiatry clinic is held monthly.

The practice provides telephone consultations, pre bookable consultations, urgent consultations

Why we carried out this inspection

We carried out this inspection to follow up the breaches of regulations identified at the previous inspections. This provider had been inspected on two occasions, once as part of the pilot programme of inspections in July 2014,

when compliance actions and a warning notice were issued to improve and again in February 2015. The practice was then rated as requires improvement and compliance actions (now known as requirement notices) to improve, were again issued.

How we carried out this inspection

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

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

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

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

Following the inspection in February 2015 an action plan was submitted by Dr Kumar indicating the actions that would be taken to meet the required regulations. Before visiting, we reviewed this action plan and asked other organisations to share any information. We carried out an announced visit on19 August 2015. We spoke with all staff on duty during the inspection; these were the GP, the practice manager, the practice nurse, the receptionist and the medical secretary. We spoke with two patients who used the service. We observed how people were being cared for and reviewed the treatment records of 10 randomly selected patients.

Inadequate

Are services safe?

Our findings

Safe track record

As at the last inspection in February 2015, we were told national patient safety alerts as well as comments and complaints received from patients, were used to identify issues that could affect either patient safety or that of the safe running of the practice. The practice manager told us staff meetings were used to disseminate this information. We found no documented evidence to verify this. We were also told that to date no complaint received from a patient had resulted in any change to the practice. Practice meeting minutes we reviewed dated March 2015 and June 2015, gave no indication if national safety alerts had been received or actioned. Staff we spoke with were aware of their responsibilities to raise concerns, and they said they would report incidents and near misses to the practice manager.

Learning and improvement from safety incidents

The practice had not sustained a systematic approach to documenting, investigating and evidencing learning from any significant event or incident.

We reviewed two significant event analyses (SEA) that had occurred since the last inspection in February 2015. One was a data management issue dated May 2015 and the other was an incident dated 10 June 2015, when medication had been delivered by the pharmacy to the wrong address of a patient.

On the documented SEA in May 2015 there had been an A4 sheet added that stated the incident had been discussed at a practice meeting. We could find no evidence of this when we reviewed the practice meeting minutes dated 16 June 2015, apart from a reminder to staff to check patients details on blood test request forms .There was no explanation as to reason for this reminder and no reference to a SEA. The medicines incident was documented and all staff had signed the bottom of the document to verify that they had read it. Again there was no evidence that this had been discussed or documented at the following practice meeting.

Reliable safety systems and processes including safeguarding

Staff had a good understanding of what constituted a safeguarding incident. We saw the staff had access to the contact details for the local authority safeguarding team. When we spoke with the most recently appointed member of staff they were able to explain how they would escalate any safeguarding incident. They told us they had received safeguarding training from the practice manager during a practice meeting. We did not see any evidence to verify this training. We only saw one certificate of external safeguarding training for the practice nurse. The GP was the safeguarding lead and had undertaken the required level 3 training.

The practice had a chaperone policy. The practice manager confirmed that only staff who had received training in the role and responsibilities of chaperoning carried out this role. A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

Medicines management

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.

Emergency medicines were stored in the practices nurses' room. These were readily available. All expiry dates were recorded and monthly checks were undertaken and documented.

Blank prescription forms were tracked through the practice and kept securely at all times. This

was in accordance with national guidance. The practice contacted patients on a weekly basis if prescriptions were not collected.

Vaccines were managed well by the practice nurse. Stock rotation was evident and the cold chain maintained as required. This ensured that vaccines were stored and transferred correctly, then maintained at the required temperature for storage and use. Temperature checks on the vaccine fridge were undertaken and recorded daily.

Cleanliness and infection control

There was a current infection prevention and control (IPC) policy in place, with the GP identified as the lead for IPC. We saw a basic IPC audit at the last inspection in February 2015.

There was a one page document titled "Infection Control Quick Look" in the IPC policy. This was signed by the GP and dated 17 August 2015, however this was not an audit of

current IPC practices but an instruction to staff to follow hand decontamination procedures. It also stated that the IPC leads were the GP and the practice nurse and that the leads must have appropriate knowledge and experience in hygiene microbiology. The practice nurse informed us that they were unaware that they were cited as a lead for IPC and there was no evidence of appropriate training for the GP or the nurse as leads and no basic IPC training documented for any of the staff.

The practice was found to be clean and tidy. We saw the consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/ consulting rooms.

The practice manager informed us there was a cleaner employed and that cleaning schedules were in place. We did not see any evidence of these schedules or evidence of continued monitoring of these schedules.

Records were available to indicate that risk of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal) had been assessed as low risk. This was to be reviewed annually.

Equipment

Staff did not raise any issue about the availability of equipment. We saw that equipment in the practice was in satisfactory condition. Annual portable appliance testing (PAT) had been due in July 2015. The practice manger informed us they were waiting for the company to contact the practice.

The practice had equipment in the waiting room to enable patients to self-check their weight and blood pressure. Instructions were clearly displayed, with advice to patients to speak with staff if they wished to discuss the results.

Staffing and recruitment

The practice had a comprehensive recruitment policy; however this had not been fully implemented during the latest recruitment.

The practice had employed one new staff member since the last inspection. We saw the personnel file contained most of the required information such as criminal records checks with the Disclosure and Barring Service (DBS), identity checks, references and contract of employment.

However we saw only one interview note template had been completed, despite verification that both the GP and practice manager had undertaken the interview. The interview template was not in sufficient detail to demonstrate the questions asked in order to gain assurances of the competencies required for the role. Also there was no application form for the post in the file so any gaps in employment could not be discussed or corroborated at interview.

There was no evidence of an end of the three month probationary period appraisal or meeting, despite the staff member confirming this had taken place; having been employed since March 2015. The practice manager informed us this had been sent to an external organisation who had been contracted since 4 August 2015, to provide HR policies and procedures. We were told the practice now had an electronic system for HR guidance. On asking the practice manager to demonstrate this, we were informed they were still waiting for their password to enable them to access these.

The practice manager explained that once the current vacancy for an additional receptionist was filled the staffing establishment would be at the agreed level.

Monitoring safety and responding to risk

At the last inspection the practice had shown some improvement in reporting, recording and monitoring significant events. Again we were told that incidents were reported at practice meetings but the two meeting minutes provided did not have standard agenda items and it was difficult to establish how the practice systematically monitored safety and responded to any identified risk. The GP and practice manager showed little insight into the need or importance of effective systems and processes to improve patient safety and identify and reduce risks.

Staff had received cardiopulmonary resuscitation (CPR) training in February 2015 for adults, children and babies and in the use of an Automated External Defibrillator (AED), with training certificates available for all staff.

We did not see a risk register for the practice and there were no current risk assessments to identify and manage risks to patients and staff. The risk assessments seen were completed following incidents, such as spillage on the staircase. General risk within the practice was not assessed proactively, but rather reactively.

Inadequate

Are services safe?

Staff covered each other's duties in reception and administration in the event of unexpected absence.

There was an appointed fire marshal and the last fire drill was undertaken on 17 August 2015.

Arrangements to deal with emergencies and major incidents

There was now oxygen available for use on the premises during any medical emergency. However there was no defibrillator or Automated External Defibrillator (AED) available and as at the last inspection in February 2015, there was still no risk assessment or protocol showing the rational explaining this decision. There were no policies or procedures available for staff to follow in the event of any health care emergency, which could occur in the practice. This is particularly important as the surgery opens at 9am but there is no clinical cover until after 10am. This had been highlighted at the inspections in July 2014 and in February 2015.

The practice manager insisted that the Home Visit Request guidance, kept in the home visit record book, gave staff guidance on what to do in an emergency. She also informed us that emergency scenarios had been undertaken with staff during practice meetings. There was no documentary evidence to verify this. There were no training records or evidence within the practice minutes provided. The home visit request guidance had a section at the bottom relating to calling an ambulance in an emergency, but this did not relate to any medical emergency within the practice but situations that could present, such as chest pain, when a patient contacts the practice by telephone, requesting a home visit.

The GP provided us with two examples when patients were triaged straight to A&E, having been assessed as an emergency, after they had arrived at the practice for routine appointments.

There was a contingency plan box within the reception office. This included a business continuity plan. Risks identified included power failure, loss of telephone and IT services, staff absence and access to the building. The document also contained relevant contact details for external contractors.

Arrangements were also in place with other local GPs in the event that the premises were unable to be used, to cause minimal disruption for patients.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

At the last inspection in February 2015 we were told the GP and practice nurse carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. This was again reiterated to us during this inspection.

The practice did not have a system in place to ensure all clinical staff were kept up to date. The practice clinical governance policy stated that staff were to maintain knowledge of current developments and research, but it was not clear as to how this was achieved. We were told the GP had access to guidelines from NICE and used this information to decide how care and treatment was to be delivered to meet patient needs.

We were told care plans were in place and kept updated, in line with national guidelines for patients with long term conditions and for those patients who met the criteria to avoid unplanned admissions to hospital.

The practice did not have any written guidance in relation to the Mental Capacity Act (MCA) 2005 or how the staff would assess the best interests of patients. The GP had undertaken update training in the MCA 2005 but there was no evidence that this had been disseminated to the rest of the practice staff.

Patients we spoke with said they felt they received care appropriate to their needs. New patient health checks were either carried out by the practice nurse or GP, and health checks and screenings were undertaken in line with national guidance.

There were no specialist clinics run by the practice as the GP led on all long term and complex medical conditions, with input from the practice nurse for the management of patients with asthma.

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). Current results were 881.5 of the total number of 897 points available. Data selected from Public Health England showed:

- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 91.8%, higher than the Clinical Commissioning Group (CCG) of 72.6 % and the national average of 80.1%
- The percentage of patients on the diabetes register who had a record of retinal screening was 83% , compared with 80.1% for the CCG and national average of 82.6%
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 75% , slightly below the CCG average of 78.3% and the national average of 77.9%
- The percentage of older patients who had received influenza immunisations was comparable at 83.9% with the local Clinical Commissioning Group (CCG) of 81.4% and the national average of 81.6%

Cervical smear uptake rate remained low at 53.1% compared with the CCG average of 71.8% and the national average of 81.8%. This was discussed at the inspection in February 2015. The practice nurse explained that opportunistic testing took place when women came for general appointments. The practice continued to raise this issue amongst patients, with notices promoting cervical smears and raising awareness via the next Patient Participation Group meeting.

As at the last inspection in February 2015 the practice manager confirmed that contact was made with the health visitor and district nurses whenever required and a file was maintained daily to ensure this contact was made to refer patients when needed. We did not see any evidence of recent multidisciplinary meetings, were patient's care and treatments had been discussed. We did not see or were provided with any evidence of any meetings with external clinical professionals, such as midwives, health visitors or the palliative care team.

The practice still did not have a system in place for completing clinical audit cycles. There was no plan in place for undertaking clinical audits in the future. This was highlighted at the last inspection. We found the GP had not undertaken a full audit cycle to evaluate the quality, impact or success of care and treatment. The GP had undertaken a case review of a patient recently diagnosed with cancer

and a review of the 2% of patients determined to be "most vulnerable" within the practice population. We saw no evidence that these reviews had been shared or discussed with other practice staff. Patient outcomes were hard to identify as little or no reference was made to audits and there was no evidence that the practice was comparing its performance to others; either locally or nationally.

The practice was participating in a medicine optimisation programme. This was led and undertaken by a pharmacist employed by the local Clinical Commissioning Group (CCG). This was to ensure that patients were receiving the most cost effective medicines, as recommended by national guidance.

Medication reviews for patients on multiple and frequently prescribed medicines had not been undertaken. This shortfall was also found at the last inspection in February 2015. Alert flags on the electronic system for five patients, diagnosed with learning difficulties were out of date – one alert said the review was due in 2007. An additional five randomly selected patients also had no medication reviews undertaken and alerts were out of date. The GP insisted that these had been undertaken and repeatedly insisted the system would not update the alert until nearer the next review date. When we asked to cross reference the review dates with the clinical consultations for these patients, medication reviews were not recorded so there was no evidence that these had been completed. This was also the case at the last inspection.

Effective staffing

The GP practice team included one male GP, a practice nurse, one practice manager, a secretary and two receptionists. At the time of this visit the practice was actively recruiting an additional receptionist. The practice nurse worked eight hours per week. These were split between Tuesday afternoon and Wednesday morning. Patients requiring nursing treatments outside these times were referred to the district nursing service.

We saw recent appraisals had been undertaken for the practice nurse, reception staff and the medical secretary. However these mainly consisted of staff self-appraisal with no evidence of performance monitoring, identification of personal or professional development.

We looked at one induction training record for the latest recruited member of the reception team. This included some mandatory training, such as cardiac pulmonary resuscitation (CPR) and role-specific training.

The practice did not maintain a record of completed training by staff or a matrix of training to be undertaken. It was difficult to verify what training staff had completed, requested or if outstanding. This was raised at the last inspections in July 2014 and February 2015.

Certificates of training demonstrated the practice nurse was appropriately trained and updated to undertake clinical checks such cervical cytology, immunisations and vaccination and spirometry (lung function tests). We were told that apart from CPR training, the clinical training had been completed at or supported externally by another practice.

Working with colleagues and other services

The practice staff contacted the health visitors once a week to provide relevant updates on the birth of new babies and clinical or safeguarding concerns. Weekly ante-natal clinics were held at the practice, managed by the community midwives.

We were told the practice worked closely with other health care providers in the local area. The practice manager attended meetings with other managers of single handed GP practices. We were told these meetings provided opportunities for supporting each other, sharing information and good practice and reviewing national developments and guidelines. There was no evidence that any of this information was shared with other staff members.

When the surgery was closed patients were advised to contact the NHS 111 service. Out of hours care was provided by Preston Primary Care Centre based at the local NHS hospital.

Patients were also referred to external health professionals for phlebotomy (taking blood for tests) as this was not undertaken by the practice. When the practice nurse was not on duty patients were referred to the district nursing service for treatments such as change of dressing and wound checks.

Information sharing

Inadequate

Are services effective?

(for example, treatment is effective)

Information was received on a daily basis from the Accident and Emergency department and the out of hours service when patients attended. Patients who had attended these services were then contacted by the practice manager if required.

We were told the practice manager was responsible for taking action with all letters and communication that came into the practice from external health and social care organisations, for example following patients discharge from hospital. Updates were added to the patient's electronic record by the practice manager and the mail passed to the GP for his attention. All mail was then scanned on to the electronic system by the secretary.

Any information in relation to patients who were receiving end of life care was faxed over to the out of hours service as required.

Consent to care and treatment

There was no progress since the last inspection in practice staff having access to a current consent policy. There was no consent policy in the policy folder provided. We were not provided with an updated policy or any guidance that related to the taking of consent or in relation to the Mental Capacity Act 2005.

The practice nurse demonstrated a good understanding of Gillick competencies. (These help clinical staff to identify young people who were aged under 16 who have the capacity to consent to medical examination and treatment). The practice nurse explained she was involved in the care and treatment for young people who required contraceptive or sexual health advice.

Health promotion and prevention

The practice offered a health check to all new patients registering with them. They offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

The practice provided health promotion information to patients. For older patients there was an influenza and shingles vaccination programme.

There was a range of information on separate notice boards for older and young patients in relation to health and wellbeing and also contacts for various health and social care services in the local community.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were polite and helpful to patients both attending at the reception desk and on the telephone. Patients were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during any examinations, investigations and treatments.

The NHS England- GP Patient Survey published on 4 July 2015 told us, of the respondents:

- 67.6% said the GP was good at treating them with care and concern – CCG average 85.4% National average 85.1%
- 74.6% said the GP they saw or spoke to was good at giving them enough time – CCG average 87%, National average 86.8%
- 71.4% said the GP they saw or spoke to was good at listening to them - CCG average 88.3%, National average 88.6%
- 63.3% said the GP they saw or spoke to was good at involving them in decisions about their care - CCG average 82.6%, National average 81.5%
- 87.7% said they had confidence and trust in the GP they saw or spoke to - CCG average 94.6%, National average 95.3%
- 89.3% said the nurse they saw or spoke to was good at giving them enough time- CCG average 92.2%, National average 91.9%
- 84.3% said the nurse they saw or spoke to was good at listening to them - CCG average 91%, National average 91%
- 84.4% said the nurse they saw or spoke to was good at treating them with care and concern - CCG average 90.4%, National average 90.4%

We noted there were 435 survey forms distributed for the practice and 82 forms were returned. The practice therefore had a relatively low return rate of 18.9%.

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 and carer support to cope emotionally with care and treatment

Patients we spoke with said they did feel involved in decisions about their care.

Results from the national GP patient survey we reviewed showed patients generally responded positively to questions about their involvement in planning and making decisions about their care and treatment, but results were below local CCG and national averages. For example:

- 71.8 % said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85.8%% and national average of 86.3%.
- 63.3% 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 81.5%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice manager explained that they were aware of the needs of the practice population. We were told appointments were flexible to meet the needs of patients, for example those with long term conditions and those patients with learning disabilities, would be offered longer appointments. However there was no documented evidence that the practice had effectively assessed the needs of its patient population or had engaged with the local Clinical Commissioning Group to secure future service improvements to meet patient needs.

Home visits were made to older patients and those vulnerable housebound patients when required and a log of home visits carried out was maintained.

The practice continued to use its own electronic clinical system facility (Booking Management), to refer patients into secondary care; for example for a hospital consultation. Once a referral was requested, this was transferred to the secretary to print off and send.

The practice had an active Patient Participation Group (PPG). The practice manager and the GP attended the PPG meetings on a regular basis. We saw invites posted in the waiting room for the next meeting in September, were a number of guest speakers were booked to discuss bowel screening and cervical smears.

Tackling inequity and promoting equality

Since the last inspection the practice had joined a CCG led scheme to ensure the availability of a translator via language line.

We were told by the practice they were providing services for patients who were seeking asylum in this country. However there was no explanation of any additional support provided for these patients.

An equality and diversity policy was available. This had been seen at the inspection in February 2015. There was still no documented evidence to demonstrate if staff had received any training or updates about equality and diversity issues.

The building had disabled facilities including ramp access and toilet facilities. The GP and practice nurse consultation rooms were located on the ground floor and an additional consultation room could be used by patients who required privacy for breast feeding or to discuss concerns privately with reception staff.

Access to the service

The practice was open Monday to Friday 9 am until 6 pm except Thursday afternoon when the practice closed for a half day. An extended surgery was held each Monday until 7pm for those patients who worked. As at the last inspection we were informed that emergency slots were allocated for 11 and 12 am and 17.40 and 17.50 each day when the surgery was open.

The NHS England- GP Patient Survey told us, of the respondents:

- 77.2 % of patients said they could get through easily to the surgery by phone compared to the CCG average of 71.6% and national average of 74.4%.
- 72.5 % of patients were satisfied with the practice's opening hours compared to the CCG

average of 72.6 % and national average of 75.7%.

- 80% of patients said they were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83.7% and the national average of 85.4%

However only

- 59.9% of patients said they would recommend this surgery to someone new to the area compared to the CCG average of 77.5% and the national average of 78%

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and the practice manager was the designated responsible person, who handled all complaints in the practice.

The practice manager informed us there had been no complaints since the last inspection, with only one documented complaint in the last 12 months. This was reviewed at the last inspection in February 2015. The practice manager told us the outcome or learning of any complaint would be shared with staff but that to date no complaint had led to any changes being required.

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

At the last inspection in February 2015 we did not see a written strategy or business plan for the practice. These were still not in place. When we spoke with staff we were told the practice vision was to continue to be a proactive and caring practice.

A mission statement was displayed in the waiting room and was available on the practice web site.

Governance arrangements

There was little improvement in the governance arrangements of the practice. The practice had some policies and procedures in place to give staff guidance. Policies were only available in paper copy. Most had been reviewed in September 2014. We had spoken about a shared drive at the inspection in February 2015 to store policy guidance electronically to enable easier access for staff.

The practice did not hold regular governance meetings and issues were discussed in an ad hoc manner. The GP had implemented a clinical governance policy seen at the last inspection, dated September 2014, which covered areas such as clinical audit (stating regular clinical audit would be undertaken), risk control, staff management, information governance, continued professional development and patient experience. We did not see any recent evidence of management or review of any of these areas.

The practice did not have formal arrangements for identifying, recording and managing risks, for example responding to emergency medical procedures.

Leadership, openness and transparency

Staff told us that they found both the GP and practice manager approachable and would have no hesitation in raising any issues with either. Staff were aware of the term whistleblowing. Staff said they had access to a policy in the staff room but that they would also look at the CQC website for further guidance.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active Patient Participation Group (PPG). The practice manager and the GP attended the PPG meetings on a regular basis, where opportunity for good information exchange took place. The last meeting was in April 2015 and the minutes of the meeting were available on the practice web site and a copy was on the notice board in the waiting room.

The practice was taking part in the Friends and Family Test. This is an NHS scheme to get patients opinion of a service, by asking if they would recommend that service to friends or family members. The practice manager said to date the feedback had been positive but that the numbers of patients who were participating was low. Patients could complete hand written cards in the surgery or complete on line via the practice web site.

A “niggles and grumbles” book was kept in the waiting room for patients to document any issue.

Staff told us that at practice meetings they had the opportunity to raise any issue and give feedback on the service or suggest any improvements. The practice meeting minutes or appraisal documentation seen did not give any evidence of this.

Management lead through learning and improvement

We saw no evidence of clinical audits being completed, and there was no future programme suggesting what clinical audits would be undertaken.

Although staff confirmed they had all undergone appraisals since the last inspection, the appraisal documents contained only self-evaluation against a set of questions. There was no performance management, personal or professional development or training needs identified. There was also no signature of the appraiser on two of the three appraisals seen.

The GP had undergone an appraisal and was gathering evidence and information required for their professional revalidation. This is the process whereby doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice.

The practice nurse was registered with the Nursing and Midwifery Council, and as part of this annual registration was required to update and maintain clinical skills and knowledge. We saw evidence of updated training and learning undertaken.

Are services well-led?

Inadequate

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

Following the last inspection in February 2015 an action plan was submitted by the GP. There remain shortfalls in evidence seen at this inspection to fully demonstrate that the action plan has been achieved, despite having a completion date of 05/05/2015 and being signed by the GP.

There continued to be shortfalls in how the practice was managed and effectively learned and improved.

- The system to review policies and procedures was still not efficient.
- There was still no central register of policies
- There was still no central register of training to demonstrate that staff had undertaken or were due to complete.
- The GP had not still implemented a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy.
- The consent policy still had not been updated to include information in regards to the Mental Capacity Act 2005.
- The recording and analysis of, and learning from any incident remained ad hoc, with little evidence of learning disseminated to staff.
- The maintaining of accurate and up to date records of clinical treatment, particularly medicines reviews, for patients was still not effective.
- There was still little evidence that demonstrated the practice continually assessed, monitored and improved the quality and safety of the service provided.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014** (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, (b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and (c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role. There continued to be shortfalls in how staff training was organised and recorded to demonstrate appropriate training and support to undertake their roles. .

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014 **17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d) maintain securely such other records as are necessary to be kept in relation to— (i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

This section is primarily information for the provider

Enforcement actions

There continued to be shortfalls in the systems in place to assess and monitor the quality of the service provided and manage and record effectively the training and development of staff.