Dr Sharif Hossain

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Dr Sharif Hossain on 22 September 2016. The overall rating for the practice was inadequate and the service was placed in special measures for a period of six months. The full comprehensive report from the inspection undertaken on 22 September 2016 can be found by selecting the 'all reports' link for Dr Sharif Hossain on our website at www.cqc.org.uk.

As a result of our findings from this inspection CQC issued a requirement notice for the identified breaches of Regulations 12, 18 and 19 and a warning notice for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically we found concerns related to: the processes for identification and management of significant events, the practice's safeguarding processes, management of risks associated with infection control and fire safety, not all staff had received an internal appraisal within the previous 12 months, not all staff had completed the requisite essential training, the practice were not undertaking a regular check of staffs' professional registrations and recruitment checks did not ensure patients were kept safe.

We also issued a requirement notice in respect of breaches in regulation 13 of CQC (Registration) Regulations 2009: the practice did not have adequate indemnity insurance in place for their nursing staff.

This inspection was undertaken within six months of the publication of the last inspection report as the practice was rated as inadequate and placed in special measures. This was an announced comprehensive inspection completed on 8 August 2017. Overall the practice is still rated as inadequate.

The concerns identified on the day of the inspection included:

- There was no effective system in place for the dissemination of patient safety alerts and no evidence that all alerts were reviewed and acted upon.
- There was no effective system in place for recording and storing controlled medicines.

Summary of findings

- There was no effective system in place for ensuring that pathology results were reviewed actioned and archived into patient records.
- There was no effective system in place to monitor patients who were referred for urgent assessment and diagnosis.
- There was no effective system in place for recalling patients with long term conditions who required regular reviews or for those who required periodic reviews of their medication including those on high risk medicines.
- The practice was not following current clinical guidance and best practice.
- The practice did not keep an accurate, complete and contemporaneous account or record of the care provided for all patients.
- There was a failure to assess and take action in response to various risks including those related to fire safety.

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

- There were inconsistent accounts of the system in place for recording significant events and not all events had been documented. The practice policy for significant events was from another practice.
- Systems for mitigating risks associated with infection control were not clear or effective.
- Staff did not have the all the requisite training skills and knowledge to deliver effective care and treatment. For example some staff did not have a record of child safeguarding training and there was no evidence that clinical updates had been completed for all staff that administered immunisations and took samples for cervical screening.
- Results from the national GP patient survey indicated patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. However, both feedback from staff on the day and patient survey data indicated that some patients were unhappy with the attitude of the reception team.
- Information about how to complain was available. We found that some of the health promotion information in the reception area was out of date.
- Some patients we spoke with said they found it difficult to make an appointment at a convenient time or with their preferred GP. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was an absence of clear leadership in key areas. For example the management of patient safety alerts. Although staff told us they felt supported by management, we were told that staff had only recently been given contracts of employment with legal terms and conditions. We were told that the practice PPG was not currently active.
- The provider was aware of the requirements of the duty of candour.

Had the provider's registration not been cancelled, we would have set out the following list of 'musts' for their action:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences
- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

We made a successful application to Camberwell Magistrate's Court on 10 August 2017 to urgently cancel the provider's registration under section 30 of The Health and Social Care Act 2008 on the basis that there were several breaches of the 2014 Regulations which presented serious risks to people's life, health or well-being. The provider was referred to the appropriate professional organisations and a caretaker organisation took over the management of the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Summary of findings

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.

- The process used to report significant events was not effective. The practice did not have its own policy for reporting significant events and we found that not all events had been reported and not all staff were clear on the process for documenting events.
- There was no effective system for distributing and acting upon patient safety alerts.
- Patients were at risk of harm because there were weaknesses in the processes around safeguarding, recruitment, infection control, the medicine management, and risk management measures designed to mitigate risks associated with fire. For example not all staff had received safeguarding training and there was little evidence of engagement with the local health visitor. There was no register to monitor the use of controlled drugs and we found controlled medicines were not securely stored. Not all clinical staff had received a DBS check.
- The practice had systems in place to respond to a clinical emergency.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Although data from the Quality and Outcomes Framework showed most patient outcomes were comparable to the national average, reviews of patient records raised questions regarding the accuracy of this data. Review of records showed that care and treatment were not delivered in accordance with evidence based guidance. For example we found instances of patients on high risk medicines who were not being reviewed in accordance with current clinical guidance and best practice.
- There was no evidence of a programme to improve the quality of patient care.
- There was an absence of clinical updates for staff administering immunisations and taking cervical screening samples and not all staff had completed essential training including safeguarding and basic life support training.
- There was limited evidence of effective working with other health care agencies. For example we did not see any evidence

Summary of findings

that individual patients were discussed during the most recent palliative care and safeguarding team meetings. These meetings had exposed potential inaccuracies in the practice's palliative care and safeguarding registers.

Are services caring?

Requires improvement

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

- Care planning for patients was limited to those with palliative care needs. Practice staff had attended course on care planning recommended by the RCGP with a view to ensure that staff were able to provide effective care plans for those who required them.
- Some patients provided negative feedback in the patient survey, comment cards and during discussions with patients on the day of the inspection about the attitude of reception staff. On the day of the inspection we saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. Most patient feedback stated that clinical staff were caring and compassionate.
- Some information about local health and social care services available for patients in the reception area was outdated and the practice had no website where information about patient services could be accessed.

Are services responsive to people's needs?

Requires improvement

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

- Feedback from patients indicated that some patients had difficulty accessing appointments generally, appointments with their preferred clinician and that waiting times were long. Urgent same day appointments were available.
- Deficiencies in care planning and mechanisms to identify and monitor those with long term conditions limited the practice's capacity to effectively respond to the needs of all patients.
- The practice did not have a hearing loop but translation services were available for patients who required them.
- Information about how to complain was available.

Are services well-led?

Inadequate

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

- The practice lacked a clear vision and strategy.

Summary of findings

- There was a lack of clear leadership in the practice in key areas. There were gaps in the practice's governance framework which exposed patients to risk of harm. For example there was no clear system to manage patient safety alerts and no system in place for monitoring urgent diagnostic referrals.
- Staff had only recently been provided with employment contracts that were legal after the provider was prompted to do by an external organisation. This was despite staff raising their concerns with the provider and practice management. Therefore although the lead GP allowed staff to voice their concerns it was evident that these were not always listened to or acted upon.
- Training was lacking for staff and it was evident that the practice had no internal mechanism to independently identify their own training needs.
- The provider was aware of the requirements of the duty of candour.
- The practice patient participation group had not been active since our last inspection.
- There was no evidence of continuous learning or improvement and no systems which encouraged quality improvement.

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 providing safe, effective and well-led services and requires improvement for the provision of caring and responsive services leading to the practice being rated as inadequate overall. The issues identified impact on the care provided to this population group.

- Though staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns although we noted that none of the nursing staff had any safeguarding training on file.
- The practice offered home visits and urgent appointments for those with enhanced needs and staff provided older vulnerable patients with their personal telephone number but there was no policy around remote advice no evidence of staff being trained to provide advice remotely.
- The systems around the management of palliative care patients indicated that patients who required end of life care were not referred at an early stage to local palliative care services. Discussions with the local palliative care teams did not demonstrate discussion of specific patients with palliative care needs. We were told that the latest meeting with the palliative care team had resulted in the practice reviewing their palliative care register and identifying five further patients who required end of life support but had not been referred.
- Staff at the practice had only recently begun completing care plans for patients but this was limited to those will palliative care needs.
- Health promotional advice in area was available in the reception area but we saw that some of this was out of date.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for the provision of caring and responsive services leading to the practice being rated as inadequate overall. The issues identified impact on the care provided to this population group.

- Reviews of the patient record system raised serious concerns about the practice's ability to identify those patients with long term conditions and questions around the quality and efficacy of the care provided. For example there were instances where patients were not correctly coded on the system limiting the

Summary of findings

practice's ability to identify and provide the required care to those with chronic or long term illnesses. We saw patients who were not receiving regular tests and assessments required to ensure effective management of their condition; including patients on high risk medicines.

- Data indicators designed to measure the practice's management of patients with long term conditions were mostly in line with local and national averages. However the review of records called into to question the accuracy of this data. For example there were instances of diagnostic assessments being recorded on the clinical system without any evidence of tests having been completed in secondary care. We also found instances where patients were noted as requiring medicine to enable them to manage their condition safely. In several instances we found that despite this medicine having not been issued for prolonged periods of time, clinicians had placed entries on the clinical system noting that patients had good compliance.
- Care planning was limited for patients with long term conditions. This had been identified by The Royal College of General Practitioners (RCGP) as an area where clinicians required additional training. Clinicians had completed one of three recommended courses.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP.
- There was limited evidence of effective multidisciplinary working.

Families, children and young people

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for the provision of caring and responsive services leading to the practice being rated as inadequate overall. The issues identified impact on the care provided to this population group.

- We were told that there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk however we did not see any examples of this.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.

Summary of findings

- Appointments were available outside of school hours. We found the female toilets where the baby changing facilities were located were dirty.
- There was limited evidence of working with health visitors. We were told that the practice provided ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for the provision of caring and responsive services leading to the practice being rated as inadequate overall. The issues identified impact on the care provided to this population group.

- The practice offered extended opening hours and telephone consultations. However some patient feedback indicated that access to appointments was an issue and that appointments were often not at convenient times and not with their preferred clinician.
- The practice did not have a website therefore there was no mechanism for the practice to provide online health promotion and screening information. Some of the literature in the waiting area was also out of date.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for the provision of caring and responsive services leading to the practice being rated as inadequate overall. The issues identified impact on the care provided to this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. However issues identified with coding of patient records and recent reviews of patient records after multidisciplinary meetings suggested that this may not have been accurate or not used effectively.
- Homeless people were able to register at the practice.
- The practice offered longer appointments for patients with a learning disability.
- There was limited evidence that the practice regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations though some of this information in the waiting area was several years old.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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. However, we saw no evidence of any safeguarding referrals and there was no evidence of safeguarding training for some staff.

People experiencing poor mental health (including people with dementia)

Inadequate 

The practice is rated as inadequate for providing safe, effective and well-led services and requires improvement for the provision of caring and responsive services leading to the practice being rated as inadequate overall. The issues identified impact on the care provided to this population group.

- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%. Other mental health indicators were higher than local and national averages. However anomalies from a records review raised uncertainty about the accuracy of this data and whether care planning had been put in place.
- Records indicated that the practice's system for monitoring repeat prescribing including for patients receiving medicines for mental health needs was ineffective and did not ensure patients received their medicine or ensure that regular reviews were undertaken for those on high risk medicines.
- There was little evidence of multi-disciplinary working in the case management of patients experiencing poor mental health, including those living with dementia.
- Some of the information in the practice waiting area available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations was out of date. The practice had no website which enabled patients to access information about local support services.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages in most areas though some scores related to access were lower. Three hundred and sixty six survey forms were distributed and 93 were returned. This represented 1.8% of the practice's patient list.

- 65% of patients described the overall experience of this GP practice as good compared with the CCG average of 79% and the national average of 85%.
- 62% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 65% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 73% and the national average of 77%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards and 23 of these were exclusively positive about the standard of care received. Two of the comments cards were again positive about the clinical care received but contained negative feedback in respect of the service provided by the reception team and the waiting time for appointments.

We spoke with eight patients. They told us they were satisfied with the clinical care provided by the practice. Comments highlighted that clinical staff responded compassionately when they needed help and provided support when required. However six of the patients we spoke with raised concerns about the attitude of the reception team.

Dr Sharif Hossain

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an Expert by Experience.

Background to Dr Sharif Hossain

Dr Sharif Hossain was part of Southwark Clinical Commissioning Group and served approximately 5000 patients. The practice was registered with the CQC for the following regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services and Treatment of disease, disorder or injury.

The practice was located within an area ranked within the second most deprived decile on the Index of Multiple deprivation. The practice had a slightly higher than average proportion of working aged patients and a significantly lower proportion of patients aged over 55 compared to the national average. The practice had almost double the level of deprivation affecting children and triple the level of deprivation affecting older people.

The practice was run by one GP principal. The practice team also included one male salaried GP and two long term locums who were male and female. The practice had four nurses. The practice offered 22 GP sessions per week with booked and emergency appointments five days per week.

At our last inspection the practice told us that they had a 1500 patient increase in the previous 18 months as a result of increased registration and the absorption of patients from a neighbouring practice which had recently been closed.

The practice was open between 8am and 7pm Monday to Friday, with the exception of Monday when the practice closed at 8pm. Dr Sharif Hossain operated from Lister Primary Care Centre, London, Southwark SE15 5LJ, which were purpose built premises rented and maintained by NHS Property Services. The health centre also hosted three other GP practices as well as other services including the district nursing team and a benefits advisory service. The practice was accessible for patients with mobility difficulties.

Practice patients were directed to contact the local out of hours provider when the surgery was closed.

The practice operated under a Personal Medical Services (PMS) contract, and was signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These were: extended hours access, facilitating timely diagnosis and support for people with dementia, improving patient online access, learning disabilities, minor surgery, patient participation, rotavirus and shingles immunisation, unplanned admissions, NHS health check, smoking cessation, holistic assessments, integrated case management, ambulatory blood pressure monitoring and population health management quality standards.

The practice was part of the GP Federation Improving Health Limited.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Sharif Hossain on 22 September 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate and the practice was placed into special measures. The full comprehensive report following the inspection on September 2016 can be found by selecting the 'all reports' link for Dr Sharif Hossain on our website at www.cqc.org.uk.

We undertook a follow up inspection of Dr Sharif Hossain Surgery on 8 August 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice had made changes to ensure compliance with regulatory requirements.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including The Royal College of General Practitioners (RCGP) to share what they knew. We carried out an announced visit on 8 August 2017. During our visit we:

- Spoke with a range of staff (GP's, practice management and reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

At our previous inspection on 22 September 2016, we rated the practice as inadequate for providing safe services as:

- There was no consistent or effective process for the management of significant and staff were not aware of things that could possibly constitute a significant event and not all staff were involved in analysis and discussion of significant events.
- There was no evidence of an effective system for managing patient safety alerts.
- Arrangements to safeguard patients from abuse or harm were insufficient.
- Risks associated with infection control, staffing and recruitment, fire, equipment and the management of prescriptions had not been adequately addressed.
- One member of staff had not completed basic life support training and the practice's business continuity plan did not contain emergency contact information for staff.

Not all of these issues had been adequately addressed when we undertook a follow up inspection on 8 August 2017. For instance, not all significant events had been documented as per the stated policy and the practice policy was from another practice; staff provided inconsistent accounts regarding the management of patient safety alerts and there was no evidence of action taken in response to patient safety alerts; infection control concerns had not been adequately addressed; recruitment checks had not been undertaken for all staff working at the practice; there was no fire safety policy in place; and not all staff had received safeguarding training and there was no evidence of safeguarding concerns being escalated to the local safeguarding team.

In addition we found that medicines were not being managed safely including in respect of the storage of controlled medicines and the prescribing and monitoring of high risk medicines.

Safe track record and learning

At the last inspection we found staff were unaware of how to report significant events, not all staff were involved in significant event discussion and not all events had been documented in line with the practice's significant event protocol. There was also no effective system in place for recording action taken in response to patient safety alerts. During this inspection we found the practice policy for significant events was from a different GP surgery and significant event procedures were still not being consistently applied. The system in place to ensure action was taken in response to patient safety alerts still did not operate effectively.

- The practice had drafted a policy covering how to act upon and document action taken in response to patient safety alerts. However, it was evident from discussion with staff that this policy was not working in practice. We asked three members of staff about the process and asked about specific alerts that had recently arisen. There was no documented evidence of action taken in response to these alerts, no member of staff could verbally inform us which patients were involved and all three members of staff gave inconsistent accounts as to how safety alerts were managed.
- The practice's significant event policy was from a different practice located in a neighbouring CCG where the interim practice manager also worked. Staff told us they would inform the lead GP of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Although we did see evidence of effective reporting, learning and discussion in respect of several significant events this was not consistently applied. For example we were told of an incident involving a patient injury in the practice and it was evident from discussion with staff that this was not recorded as per the practice's policy.

Overview of safety systems and processes

At the previous CQC inspection we found that the systems, processes and practices in place to keep patients safe from abuse were not effective. For example there was no information in the practice's safeguarding policy on how to escalate concerns to external safeguarding teams, there was no evidence of any alert which had been raised with the local safeguarding team and there was limited

evidence of working with the health visitor team. During this inspection we found that although policies had been updated there was still no evidence of the practice having raised a safeguarding alert and again there were no documented minutes from health visitor meetings where patients were discussed. In addition we found a number of staff did not have a record of safeguarding training.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. Review of both the training matrix provided prior to the inspection and staff files on the day of the inspection showed that there were gaps in safeguarding training. For example the matrix indicated that none of the nursing staff had received safeguarding training. The staff files of two nurses were reviewed and did not contain any safeguarding training certificates. We asked for evidence of this training to be provided after our inspection and were told that this could not be provided until the nursing staff returned from annual leave.
- Safeguarding policies reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. We reviewed one patient record for a child who was deemed to be a safeguarding risk. We asked the practice to provide evidence that this was flagged to the local safeguarding team but they were unable to do so. There was limited evidence of the practice working with the local safeguarding team. We saw evidence that the practice had met with the local safeguarding team though there was no evidence that any patients were discussed. We were told that the practice were in the process of reconciling their safeguarding register with the patients that the health visitor team were monitoring as the practice had a number of patients on their register that the health visitor team were not aware of.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

On our last visit we found that staff and patient toilets were not cleaned to a satisfactory standard and that staff had not received infection control training since 2014. In addition there were gaps in policies relating to infection control and it was unclear from looking at practice policies who acted as the practice lead in this area. At this inspection we found that all staff had received training in the past 12 months. Again, although most areas of the practice were clean and hygienic, the patient toilets were not cleaned to a satisfactory standard.

- We observed the premises to be clean and tidy in most areas. There were cleaning schedules and monitoring systems in place. However, we found that toilets were dirty and that the curtains in some clinical rooms had not been changed since September 2016. The practice nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and staff had received up to date training. We saw evidence of a recent IPC audit. There were a number of issues the practice had addressed and several which had been flagged as needing to be escalated to the building owners. We were unable to find any evidence these concerns had been escalated.

During the previous inspection we found the practice had no system in place to monitor the use of handwritten prescriptions although a policy for this was provided after the inspection. At this inspection we found the arrangements for managing medicines did not always ensure that patients were kept safe. Although the practice had adequate systems for the management of vaccines and had a full complement of emergency medicines, a review of patient records recently undertaken by the RCGP raised concerns that patients on high risk medicines or those who required medicines to manage their long term conditions were either not being prescribed the medicine they required or were not being regularly monitored to ensure they could take their medicine safely. Additionally the practice did not have systems in place for the safe storage and monitoring of controlled medicines.

- The provider was able to outline the processes for handling repeat prescriptions including the review of high risk medicines. However during the inspection we were presented with a summary of an audit of patient records undertaken by the RCGP which reviewed 14 records of patients with long term conditions selected at random. From reviewing the audit and the clinical

systems we found serious concerns were identified in respect of each of the 14 records reviewed which undermined the integrity of the patient record system as a whole. A number of concerns raised doubts about the practice's ability to effectively manage patients' prescribed medicines to help manage their long term conditions including those medicines considered high risk. Concerns stemming from the records included; patients who were documented as having medication reviews where there was no evidence of any tests being requested or stored on the computer and/or no record of an appointment which corresponded to the documented date of review. On several records we found patients with long term conditions including diabetes and hypertension who were prescribed medication to manage their condition though this had not previously been issued for years. For these patients subsequent reviews had been noted on the system where the patient's compliance with medicines was recorded as being good despite the patients not having received a prescription for several years. One patient had been prescribed warfarin but there was no evidence of this having been issued since early 2016.

- We saw evidence that the practice had undertaken audits of their prescribing in an effort to reduce antibiotic prescribing and that this had reduced and was now in line with local averages.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) but did not have procedures in place to manage them safely. For example we found a supply of morphine sitting unsecured in the staff reception area. The practice told us that they had purchased this medicine as per CQC guidance on emergency medicines in general practice. However there was no system to record the practice's supply of this medicine. After raising the need for this medicine to be secure the lead GP attempted to store the medicine in a cupboard in the treatment room labelled "controlled drugs". The cupboard was locked and inaccessible so the lead GP stored the medicine in an adjacent cupboard. Staff were unable to locate a key for the controlled drug cupboard so we were not able to access the cupboard to check if other controlled medicines were onsite though we were told there were no others.

At the last visit we found the practice was not undertaking all necessary recruitment checks for staff working at the practice and there was a lack of medical indemnity insurance in place for nursing staff.

At this inspection we reviewed four personnel files and again found gaps in the recruitment check information that should have been gathered prior to employment and for some staff there had been no checks undertaken at all. For example there was no proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body, indemnity cover and the appropriate checks through the DBS for the interim practice manager or for a locum GP. The practice were also unable to produce evidence of a DBS check for one of the permanently employed GPs or one of the nursing staff in the practice and staff confirmed that this had not been completed.

Monitoring risks to patients

On our last visit we found that the practice did not have easy access to the fire risk assessment completed by the property managers, there was no evidence that fire drills had been completed and portable appliance testing had not been completed. At this inspection we again found that the practice had not paid adequate attention to fire safety risks though portable appliance testing had been completed:

- There was a health and safety policy available. However the practice did not have a specific policy which outlined what staff should do in the event of a fire as we were told by practice staff that this was responsibility of the NHS property services. A representative for NHS Property services confirmed that each practice were required to have their own fire safety policy. There was an up to date fire risk assessment for the whole building and the fire alarm was tested weekly by the property managers. Again we were told by NHS property services that each practice was responsible for undertaking its own fire drills but there was no evidence of any drill having been completed. Staff were aware of the staff who acted as fire marshals and, although there was no

practice specific fire policy, staff we spoke with knew what to do in the event of a fire and there was signage in the waiting area informing patients of the fire evacuation point.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice and the building managers had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

Arrangements to deal with emergencies and major incidents

At the last inspection we found one member of staff had not completed basic life support training within the last 12 months. At this inspection we found that the practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the area behind the reception desk.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. However, we found morphine on the emergency medicines trolley which was not securely stored. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 22 September 2016, we rated the practice as requires improvement for providing effective services as:

- Not all staff were receiving regular appraisals.
- Not all staff had completed the required essential training in accordance with current legislation and guidance.

In addition to the breaches of regulation we recommended that the practice:

- Introduce care planning for patients where this is required.
- Continue to work to improve outcomes for diabetic patients.

At this inspection we found again not all staff had completed the required training, there was again no evidence of quality improvement work. Though some care planning had been introduced and data sources indicated improved outcomes for diabetic patients; irregularities in patient records created uncertainty as to the validity of this data and therefore it was unclear if patients were receiving the care and treatment they required. There was also no failsafe system in place to ensure results stemming from urgent referrals were received from secondary care. Evidence indicated the practice system for managing pathology results was ineffective and did not ensure results were being reviewed in a timely manner.

Effective needs assessment

From reviewing patient records it was evident that clinicians working within the practice were not providing care in accordance with current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. This was particularly apparent in respect of monitoring patients on high risk medicines.

- Reviews of patients' records highlighted a lack of compliance with current evidence based guidance. For example the RCGP had prepared an audit of patients, two weeks prior to our inspection, who had been prescribed medication for high blood pressure, which carries risk of kidney damage, had not received any blood tests to check kidney function within the last 12 months. Some patients had not received a blood test within the last five years.
- Patients prescribed high risk drugs such as lithium, methotrexate and warfarin were also not being monitored appropriately.
- We were told the practice had appointed a pharmacist to review the treatment of 900 diabetic patients to ensure that their care and treatment were optimised. Reviews undertaken of diabetic patients by the RCGP showed that care and treatment was not optimised and in some instances patients had not been reviewed or received their prescribed medication for years. No action had been taken by the practice in response to the findings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%.The practice's exception reporting rate was 2.8% compared to the local average of 6.7% and the national average of 9.8% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

At the last inspection we recommended that the practice take action to improve outcomes for diabetic patients. From reviewing the QOF indicators it appeared as though action had been taken and improvements made. However a review, of patient records raised questions as to whether diagnostic reviews and treatments required under QOF had actually occurred. Each of the records reviewed contained anomalies which raised questions about the validity of assessments undertaken. For example there were records with: diagnostic assessments but no corresponding patient appointments; test results with no evidence that external assessments had been undertaken; and details of treatment provided to patients who were deceased. Additionally there were a number of instances where

patients' conditions were not correctly coded on the system which raised questions regarding the accuracy of the practice's long term condition registers and indicated the practice was not aware of all patients with chronic conditions. This limited the practice's ability to offer appropriate treatment to those with chronic diseases.

The practice was an outlier in respect of the number of patients with atrial fibrillation who met particular diagnostic criteria who were treated with anti-coagulation drug therapy. The practice achieved 73% for this indicator compared with 86% in the CCG and 87% nationally. The practice had not exception reported any patients compared with 11% in the CCG and 10% nationally. This was discussed with the practice and we were advised that the absence of exception reporting meant that the figures were comparable.

The practice had higher rates of exception reporting for patients with cancer; 33% compared to 20% in the CCG and 25%. We were not provided with any explanation for the higher than average exception reporting for this condition.

The practice was prescribing almost double the number of antibacterial medicines compared with the CCG and was about one third higher that the rate nationally. The practice had undertaken an audit with CCG of co-moxicla, Cephalosporin's, Quinolones. As at January 2017 the practice was comparable to the local and national average for their prescribing of these medicines.

This practice was not an outlier for any other QOF (or other national) clinical targets according to the official data. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example the percentage of patients who had well controlled blood sugar was 68% compared with the CCG average of 70% and the national average of 78%. The practice's rate of exception reporting for this indicator was 4% compared with the local average of 7% and the national average of 13%. The percentage of patients who had controlled blood pressure was 78% compared to the local average of 75% and the national average of 78%. The rate of exception reporting for this indicator 2% compared with the local average of 6% and the national average of 9%.
- Performance for mental health related indicators was higher than the CCG and national averages. For example the percentage of patients with complex mental health problems who had an agreed care plan in their notes was 97% compared with 87% locally and 89 nationally. The rate of exception reporting for this indicator was 3% compared with 5% in the CCG and 13% nationally. The percentage of patients with complex mental health problems who had their alcohol consumption recorded in their notes was 100% compared with the CCG average of 86% and the national average of 89%. The practice had exception reported no patients compared with 4% in the CCG and 10% nationally.

There was no evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last two years, both of these were completed audits related to prescribing targets. Although both audits showed a reduction in prescribing to a level closer to the CCG targets neither audit was designed to improve the quality of clinical care. We were also shown a document that referred to vitamin B 12 deficiencies; this again did not demonstrate any quality improvement. The practice had also reviewed their urgent referrals and found that all referrals were appropriate.

Effective staffing

Evidence reviewed on the day of the inspection did not show that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Role-specific training was present for staff but much of this appeared to be out of date. For example all of the clinical update training on file for the member of nursing staff we reviewed was from late 2013 or early 2014. The GPs in the practice were enrolled in clinical update courses to improve care planning. We were told that they had attended one of three training sessions.
- We did not find up to date training for staff administering vaccines and no evidence of cervical screening training or updates for the nurse whose file we reviewed.
- Though there was evidence of appraisals on file for staff it, was evident that the practice was not using these as a collaborative tool to support staff development and well-being. The appraisals reviewed made reference to

the fact that staff were not receiving statutory holiday entitlement or pension contributions. We were also told by a member of the PPG that they had been involved in the staff appraisal process.

- Not all staff had received essential training that included: safeguarding, basic life support and information governance. We asked the practice to provide training certificates for training that was not present after our inspection. We did not receive any additional training evidence after our inspection.

Coordinating patient care and information sharing

It was evident that clinicians did not always have the information needed to plan and deliver care and treatment. From reviewing clinical records there were entries made of diagnostic assessments which were not supported by test results. Evidence showed that test results were not consistently being reviewed in a timely fashion.

- On the day of the inspection we did not find any outstanding test results. However we reviewed a report from the RCGP which indicated that when they began working with the practice there was a backlog of 12,000 test results from between September 2016 to April 2017. The practice treated the incident as a significant event. The reason given for the backlog was that the clinicians were not aware of how to archive results. The practice then worked with the RCGP and put an action plan in place to ensure that test results were acted upon within a reasonable timeframe and that the backlog of results was cleared. However we saw evidence that the RCGP had undertaken a review of the system for managing test results in mid July 2017 and found approximately 250 results that had not been actioned or archived. This indicated that the system to ensure timely and safe management of patient test results was not effective or sustainable and we were told after our inspection that the practice did not routine review and action pathology results with a period of 48 hours and this was an area required further improvement. The action plan included training for clinicians on how to manage and archive test results. This training had not been completed at the time of our inspection.
- We were also provided evidence that from 9 September 2016 to 25 March 2017 the practice had not completed any transfer of patient records for those patients who had transferred to another GP and there was a backlog of 400. This placed patients at risk and undermined continuity of care as a patient's new GP would not have access to their medical information. This backlog was cleared prior to inspection after identification and prompting by the RCGP.
- There was no failsafe system in place for monitoring referrals for urgent tests and diagnosis from secondary care. This was raised with the lead GP who produced an audit of referrals for urgent tests with a view to assessing their appropriateness. The absence of a system for ensuring that test results were received placed patients at risk of harm as results could be may be missed or overlooked.
- The anomalies raised by the RCGP patient record audit and the lack of response from the practice to the concerns raised called into question the integrity of the patient record system. Therefore any documented evidence in the patient record regarding external patient assessments or collaborative working could not be relied upon.

It was evident that the practice had held discussions with both the local safeguarding and palliative care team. However, there was no evidence of specific patients being discussed with the health visitor team and the notes from the latest meeting appeared to only be a question and answer session regarding local safeguarding procedures. The practice provided the inspection team with an email sent to the palliative care team. The email indicated that there were 29 patients on the practice's palliative care register but only three of these were under the care of the palliative care team at the time of their meeting with the practice. The practice had undertaken a review of the register after the meeting and identified another eight patients who needed to be referred to the palliative care team. This suggested that the register was not up to date and review mechanisms were not effective enough to ensure those patients at the end of their life were referred to the local palliative care team in a timely manner when the need arose.

Consent to care and treatment

Staff were able to outline how they would seek patients' consent to care and treatment 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.

Inadequate

Are services effective?

(for example, treatment is effective)

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

Patients with chronic diseases were not correctly coded on the clinical system which called into question the accuracy of the practice's disease registers. This could have hindered the practice's ability to provide care or refer these patients for additional support.

The practice's uptake for the cervical screening programme was 74%, which was comparable with the CCG average of 77% and the national average of 81%.

As the practice nurse was not available on the day of the inspection we were unable to confirm how the practice followed up patients who did not attend for their cervical screening test and we were not able to establish if there was a failsafe systems to ensure results were received for all samples sent for the cervical screening programme and that women who were referred as a result of abnormal results were followed up. Rates of screening for bowel cancer screening were lower when compared to the local and national average: 36% compared with 43% in the CCG and 58% nationally.

Childhood immunisation rates for the vaccinations were comparable to the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice had not achieved the target in any of four areas. These measures can be aggregated and scored out of 10, with the practice scoring 8.5 (compared to the national average of 9.1). The practice informed us that they had achieved 90% for all immunisation targets for the current year.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Questions raised by the review of patient records and the practice's persistent failure to review test results in a timely fashion or implement a system to monitor urgent test results mean that we could not be assured that appropriate follow-ups were made, when abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

At our last inspection undertaken on 22 September 2016 the practice was rated as good for the key question: Are services caring? However, we recommended that the practice take action to improve the identification of carers and advertise bereavement services. At this inspection we found that the practice had increased the numbers of patients identified as having caring responsibilities and had information related to bereavement services in the waiting area. However, some patients provided negative feedback regarding the attitude of reception staff, there were limited instances of care planning and some of the information available in the reception area regarding other health and support services was out of date. Consequently the practice is now rated as requires improvement for caring.

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could not always be treated by a clinician of the same sex. The practice employed a locum female GP on an adhoc basis.

All of the 24 patient Care Quality Commission comment cards we received were positive about the clinical care provided. Patients said they felt the practice offered a good service and that clinical staff were helpful, caring and treated them with dignity and respect. Two of the comment cards raised concerns about the attitude of the reception team.

We spoke with eight patients including two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice. Comments highlighted that clinical staff responded compassionately when they needed help and provided support when required. However six of the patients we spoke with raised concerns about the attitude of the reception team.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice in line with local and national averages for its satisfaction scores on consultations with GPs and nurses but feedback regarding reception staff was below average. For example:

- 79% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 79% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%
- 83% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local average of 82% and the national average of 86%.
- 83% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 91%.
- 84% of patients said the nurse gave them enough time compared with the CCG average of 87% and the national average of 92%.
- 95% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 94% and the national average of 97%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local average of 85% and the national average of 91%.
- 73% of patients said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

There was limited evidence of care planning for patients in the practice. The clinical lead had completed one of three

care planning training sessions since the RCGP was recruited to support the practice yet care plans had only been drafted for patients on the practice's palliative care register.

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

We were told by staff that children and young people were treated in an age-appropriate way and recognised as individuals.

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

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 72% of patients said the last GP they saw was good at involving them in decisions about their care compared to the local average of 77% and the national average of 82%.
- 82% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 90%.
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the local average of 79% and the national average of 85%)

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and there was an electronic sign in system in the patient waiting area.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area however much of this information was out of date. For example we saw signs for mental health support group meetings which took place in 2015 and information about baby and lung health clinics dated 2012. The practice did not have a website which displayed health promotion or information about local support services.

The practice's computer system alerted GPs if a patient was also a carer. At the last inspection we found that the practice had identified less than 1% of their patient list as having caring responsibilities. At this inspection the practice had identified 120 patients as carers (2% of the practice list). There was a poster in the reception area directing carers to a local support group.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. At our last inspection there was no information on local bereavement services in the waiting area. We found on this inspection that bereavement services were now being advertised in reception.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our last inspection undertaken on 22 September 2016 the practice was rated as good for key question: Are services responsive to people's needs? However, we recommended that the practice work to improve patient survey scores regarding access to a preferred GP and awareness of translation services.

Though translation services were now being advertised, feedback from patients indicated concerns among some patients around access to appointments and waiting times. In addition lack of effective multidisciplinary working and lack of effective management of the practice's chronic disease registers limited the practice's ability to respond to the needs of patients in their care. Consequently the practice is now rated as requires improvement for being responsive to people's needs.

Responding to and meeting people's needs

The system for coding chronic disease patients raised questions about the accuracy of the practice's long term disease registers and there was limited evidence of working with external healthcare organisations including safeguarding and palliative care. This showed that the practice did not have adequate mechanisms to enable them to be responsive to the needs of their population. In addition some patients we spoke with reported difficulties in accessing appointments.

- The practice had no website where patients could book appointments, order repeat prescriptions or obtain information about patient services. The practice told us they were in the process of putting a website in place and that patients could still access these services via Patient Access.
- The practice did not have a permanent female clinician and this was raised as an issue by two patients on the day of the inspection. The practice told us they had interviewed a female clinician and were waiting until after the inspection to offer them a position at the practice.
- Care planning had been highlighted as a concern by the RCGP both in respect of the quality and accuracy of plans produced. Practice staff were in the process of completing a course in care planning and had drafted care plans for palliative care patients. The practice informed us they had 29 patients on their palliative care register and that three of these patients were under the care of the palliative care team. The practice told us that after a recent meeting with the palliative care team an additional five patients had been identified who required palliative care. This highlighted that the practice did not have adequate systems in place to identify patients who required additional support and ensure that these patient's needs were met.
- The practice offered extended hours between 6.30 pm and 8 pm on Monday and between 6.30 pm and 7 pm Tuesday to Friday for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- The practice had translation services but no hearing loop for patients who were hard of hearing or deaf.

Access to the service

The practice opened at 8.30 am Monday to Friday and closed at 8 pm on Mondays and 7 pm Tuesday to Friday. Appointments were available during these times. Extended hours appointments were offered between 6.30 pm and 8 pm on Mondays and 6.30 and 7 pm Tuesday to Friday. In addition to pre-bookable appointments that could be booked between two and four weeks in advance, urgent appointments were also available.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages in some areas and lower in others:

- 86% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 54% of patients said they could get through easily to the practice by phone compared to the local average of 74% and the national average of 71%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 82% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 82% and the national average of 84%.
- 62% of patients said their last appointment was convenient compared with the CCG average of 75% and the national average of 81%.
- 62% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 21% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 51% and the national average of 58%.

Around half of the patients told us on the day of the inspection that they were able to get appointments when they needed them. The other half told us that they had difficulty accessing appointments and that they would have to wait considerable amounts of time to get appointments including one patient who said that they would have to wait up to eight weeks for an appointment with their chosen clinician. We were also told by these patients that they had difficulty getting through on the telephone to make appointments. We were told at our last inspection that the practice had introduced a telephone queuing system however at this inspection we were told that this had not been introduced but there were plans for a new phone system to be put in place. Staff also said that all patients preferred to see one clinician within the practice which created delays for patients and one staff member told us that they did not think there were enough staff to meet patient demand.

The practice had a system to assess:

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

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

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the reception area.

We did not review any complaints received by the practice or the responses issued to patients.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 22 September 2016, we rated the practice as inadequate for providing well-led services as the breaches found in respect of safe and effective services indicated deficiencies in governance particularly in respect of significant events, medicines and risk management and a lack of quality improvement work. In addition the practice did not have effective policy framework in place.

We found that some of the concerns identified on our last inspection had not been adequately addressed. We also identified new concerns associated with the practice's leadership which put patients at risk; particularly in respect of oversight of the clinical record system and management of test results and urgent diagnostic referrals. The practice's current vision and strategy was limited and staff had only recently been provided with legal contracts of employment. Consequently the practice is still rated as inadequate for providing well led services.

Vision and strategy

The practice lacked a clear vision to deliver high quality care and promote good outcomes for patients.

- Discussions with the staff at the practice indicated a lack of a coherent strategy and vision. We were told that the fact that the practice was in special measures had hindered the organisations ability to plan for the future. When asked about future planning the practice told us about a number of options including partnership or merger but did not seem to be clear about which option they would likely choose in the event that they came out of special measures or how long these would take to implement. We were provided with different explanations regarding how the practice manager role would be replaced after the inspection. None of the options presented were sufficient to ensure the effective managerial oversite necessary to ensure patient safety. For example it was clear from the options considered that the practice had not considered the competencies required to fulfil the practice manager role.

Governance arrangements

The practice's governance arrangements were inadequate and the lack of good governance placed patients at risk for example:

- The staffing structure in the practice was not always clear. When we asked certain staff about roles and responsibilities, for example who took responsibility for the management of patient safety alerts, staff were unable to provide a consistent answer.
- The practice lacked effective policies and processes. There was no fire safety policy and the policy for significant events was from another GP practice. It was evident that the practice did not have adequate processes in place to ensure that pathology results were being consistently reviewed and actioned. There was also no system in place for monitoring referrals for urgent diagnostic assessments and tests.
- The practice did not have systems and processes in place to enable them to accurately assess their performance. For example reviews of clinical records indicated that the practice were not correctly coding patients with chronic diseases which meant that there was uncertainty as to whether or not those patients were being provided with the required care and treatment. This called into question the accuracy of the available performance data including the practice's QOF performance.
- There was little evidence of audits which demonstrated improvement in the quality of patient care.
- The systems for identifying, recording and managing risks were not effective and did not ensure patient or staff safety. In addition to the lack of systems for managing patient safety alerts there was ineffective oversight of infection control concerns and insufficient attention to fire safety. Furthermore the systemic issue related to poor record keeping posed a serious potential risk to all patients within the practice.
- We saw evidence that practice meetings were occurring on a regular basis.

Leadership and culture

The lead GP failed to demonstrate the required level of leadership and ability to ensure high quality care. From reviewing records patient care was not provided in a safe way.

There was a lack of effective leadership within the practice and until recently staff did not have valid employment contracts in place and had no access to holiday, sickness or pension benefits.

Are services well-led?

Inadequate

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

There was limited evidence of multidisciplinary working. We saw little evidence of meetings held with the practice health visitor or safeguarding team with the exception of one meeting where team practice hosted the safeguarding team to give a generalised talk on safeguarding.

- Staff told us the practice held regular team meetings and we saw minutes from these meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at any time and felt confident and supported in doing so. However, despite being told by staff during interviews that they felt respected we found that administrative staff had not been provided with legal contracts of employment. Upon further investigation it was evident that staff were not receiving either statutory holiday entitlement or sickness pay. New contracts of employment had been put in place once the RCGP began supporting the practice.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff were able to speak openly. We saw an example where the duty arose and demonstrated that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

There was limited evidence that the practice listened and acted upon feedback from staff and patients. The patient participation group was not active and it was evident that staff did not have valid conditions of employment despite staff having asked for full employment rights both in informal discussions with the lead GP and management and in their appraisals:

- The practice did not have an active patient participation group (PPG). We spoke with a member of the PPG who informed us that the practice had not held any meetings since our last inspection. However, they were able to detail suggestions that they had personally given to the practice in the past including hiring a permanent female GP, having walk in appointments and using telephone appointments.
- It was evident from reviewing appraisal forms and speaking with staff that they had raised concerns about their terms of employment with the leadership in the practice. However, it was only when the RCGP reviewed staff terms of employment that changes were made to their contracts.

Continuous improvement

There was no evidence of work aimed at continuous learning and improvement within the practice.