Wallis Avenue

Quality Report

The Surgery
Wallis Avenue
Maidstone
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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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Wallis Avenue is located in a residential area in Maidstone, Kent. It provides primary medical services to approximately 3500 registered patients.

We carried out an unannounced, focused inspection on 3 November 2014 as we had received concerning information about the practice. We visited the practice location at The Surgery, Wallis Avenue, Maidstone, Kent, ME15 9JJ

Summary of findings

Wallis Avenue was not rated as this was the first inspection of the practice. It was a focused inspection which means we did not inspect against all elements of the domains to enable us to give an overall rating.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- ensure that they have an appropriate process in place for assessing the needs of patients and planning their care to meet individual needs
- review the process of administration staff writing out prescriptions for patients without them being seen or assessed by a GP
- have a process in place for investigating and learning from complaints
- ensure that they have risk assessed the way patient records are stored to ensure that confidential information is not accessible to anyone but relevant practice staff
- risk assess all staff roles that do not have criminal records checks
- ensure that all staff have relevant health checks and all information relevant to safe recruitment is recorded in staff files
- ensure that all staff have regular appraisals and access to appropriate training
- ensure that there is appropriate processes in place to access and monitor risks and services and ensure that individual patient needs are monitored

In addition the provider should:

- improve access to appointments for patients and improve the process for making appointments for being seen on the same day.

Due to the concerns raised during the focussed inspection we will be completing a Comprehensive inspection early in 2015.

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?

Most staff were clear about reporting incidents, but were concerned and unclear about reporting near misses and concerns. When things went wrong incident forms were completed but there was little evidence of review. Lessons learnt were not recorded or communicated to ensure safety was improved. There were no risk assessments in place to identify and minimise risks to patient safety. Recruitment files were not complete and lacked evidence of all relevant checks having been undertaken. Administrative staff undertook chaperone duties and had received training, however they did not have a criminal records check. There were no risk assessments to determine whether this was appropriate and safe. There was insufficient information for staff to understand and recognise risks to patient safety. Safety was not discussed at meetings and procedures were not in place to ensure the safety of staff and patients.

Medicines on the premises were kept securely and monitored appropriately. However, we identified areas of concern regarding an understanding of prescribing responsibilities.

Are services effective?

Care and treatment was not always delivered in line with recognised professional standards and guidelines. The practice did not monitor clinical outcomes for patients and there was no evidence that the practice compared its performance to others, either locally or nationally. There was no programme of clinical audit and there was no evidence that the practice audited the standards of care it provided. Although the practice provided care for two large nursing homes there was minimal evidence of engagement with other providers of health and social care or multidisciplinary team working. There was limited recognition of the benefit of an appraisal process for all staff and little support for any additional training that may be required.

Are services caring?

Information from the 2013 national patient survey and a 2014 survey of patients undertaken by the practice, showed patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with compassion. However not all felt cared for, supported and listened to, or treated with dignity. Information was available to help patients and carers understand the care available to them.

Summary of findings

Are services responsive to people's needs?

Patients reported considerable difficulty in accessing a GP and poor continuity of care. Appointment systems were not working well and needed review to ensure patients received timely care when they needed it. Patients reported that they had to queue in all weathers to obtain an appointment on the day. The practice had not responded to the concerns raised by patients about the appointment system. They had not addressed the issues around patients having no continuity of care.

There was no evidence that the practice had reviewed the needs of their local population or put in place a plan to secure service improvements. Patient feedback reported that access to appointments was not always available quickly although urgent appointments were usually available the same day if they were prepared to attend the practice and queue for an appointment slot. Accessible information was provided to help patients understand the complaints system. However, there was no evidence of shared learning from complaints with staff.

Are services well-led?

The practice did not have a clear vision and strategy to deliver well led services. Staff we spoke with were not clear about their responsibilities in relation to delivering a practice vision. There was no clear leadership structure and staff did not feel supported by management. The practice had a number of policies and procedures to govern activity. However these all appeared to have been produced some time ago as they contained out of date information. The practice did not hold regular governance meetings and there was no evidence that concerns were discussed. The practice had not proactively sought feedback from staff or patients. Although the practice had a patient participation group (PPG) this was poorly attended and PPG discussions did not reflect practice wide concerns. Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

What people who use the service say

We spoke to 13 patients during our inspection. All but one of the patients we spoke with said that they felt the practice had changed for the worse over the last year. Patients said that overall the reception staff were very polite and helpful but that they were often curt when under pressure and unable to sort out appointments. Patients found the use of locums was unhelpful as they changed often. Patients felt no one in the practice knew them well and they had to provide the same information to another GP each time they had an appointment.

Patients did not feel they were listened to and said that usually they were rushed and given a prescription rather than having further investigations or tests. Some of the patients had made complaints about one GP as they did not feel they had given them sufficient support or correct treatment. They said they received an apology from the practice but the complaints were not suitably dealt with to ensure that the same issues did not happen again. In two instances patients said that nothing had changed since making their complaints and similar concerns were raised again. These patients said they now would only see the main GP.

Patients stated that it was very difficult to get an appointment. They told us they were expected to stand in a queue from before 8am, in all weathers, in an unprotected area, to try and make an appointment to see a GP. Patients also said that once they were seen by a receptionist, they did not immediately see a GP. Instead, they were given an appointment for some time in the day. Patients said this often meant they had to go home and return to the practice later. Patients we spoke with did not feel this system supported them to access medical services when they needed them. Older patients and those with young children found the system particularly difficult.

Most of the patients we spoke with said that they were actively looking to see if they could change practices as they were not satisfied with the appointments or care they had received.

Areas for improvement

Action the service MUST take to improve

- ensure that they have an appropriate process in place for assessing the needs of patients and planning their care to meet individual needs
- review the process of administration staff writing out prescriptions for patients without them being seen or assessed by a GP
- have a process in place for investigating and learning from complaints
- ensure that they have risk assessed the way patient records are stored to ensure that confidential information is not accessible to anyone but relevant practice staff
- risk assess all staff roles that do not have criminal records checks
- ensure that all staff have relevant health checks and all information relevant to safe recruitment is recorded in staff files
- ensure that all staff have regular appraisals and access to appropriate training
- ensure that there is appropriate processes in place to access and monitor risks and services and ensure that individual patient needs are monitored

Action the service SHOULD take to improve

- improve access to appointments for patients and improve the process for making appointments for being seen on the same day

Wallis Avenue

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a CQC inspection manager.

Background to Wallis Avenue

Wallis Avenue is located in purpose built premises in a residential area of Maidstone. It provides primary medical services to approximately 3500 registered patients. The practice has one GP as the Registered Provider, a salaried GP, a practice nurse, a healthcare assistant, a finance manager and five administrative staff who cover reception and secretarial duties, one of whom is designated as the deputy practice manager. There is no practice manager in post and the lead GP stated that this was part of their own role with support from the deputy and administrative team. The practice regularly used locums to cover the workload.

We visited the practice location at The Surgery, Wallis Avenue, Maidstone, Kent, ME15 9JJ.

The practice has opted out of providing Out-of-Hours services and uses the services of a local Out-of-Hours provider. Information on how to access this service is displayed in the practice, on the practice website, and in a practice leaflet.

The practice holds a General Medical Services contract and has funding for a number of Enhanced Services, such as smoking cessation, avoiding unplanned admissions and alcohol risk reduction.

Why we carried out this inspection

We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 on 3 November 2014, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Prior to the inspection we spoke with the Medway Clinical Commissioning Group, NHS England local area team and local Healthwatch to seek their feedback about the service provided by Wallis Avenue. We also spent time reviewing information that we hold about this practice.

The inspection team carried out an unannounced visit on 3 November 2014. During our visit we spoke with a range of staff including GPs, nursing and administrative / reception staff and spoke with 13 patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients.

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

Detailed findings

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

However, as this was an unannounced, focused inspection we did not review all of the elements related to each domain so are unable to rate the practice.

Are services safe?

Our findings

Safe track record

We spoke with staff about how they used information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents. We saw that incident reports had been completed by staff who were aware of the incident but who were not involved in the incident being reported. The practice did not have a process to encourage staff to report incidents promptly to ensure processes were put in place to reduce any risk to patients and for individuals involved to learn from them.

Staff who were involved in incidents were not told promptly of their involvement so that they could avoid similar events in future. One of the GPs we spoke with stated that he only became aware of incidents relating to him when they were raised with him by the lead GP.

There was recording of incidents however, the recording of actions taken in response were limited to whom the information was passed to in the practice. There was no evidence of detailed investigation, analysis or learning from incidents to reduce the risk of re-occurrence. A number of similar incidents were recorded but there was no evidence these were investigated or monitored. There were no records of 'near-misses' and no clear protocol for staff to follow in relation to the reporting and investigation of incidents.

Patient safety alerts were referred to the lead GP to review, and were acted upon although there was no clear system in place for a standard process. We saw evidence, however, that a recent alert had resulted in changes to a patient's prescription.

We reviewed minutes of meetings over the last 12 months and there and saw that risks, incidents or alerts were not discussed as part of any meeting.

Learning and improvement from safety incidents

The practice had a system for reporting significant events, but there was no clear process for monitoring, analysing or learning from them. We reviewed the last nine entries in the significant event audit folder which related to adverse clinical events, mostly on the prescribing practices.

These adverse clinical events were not discussed with the GP prior to them being written up. The notes of the event were given to the GP by the management staff. There was no process in place to support the GP and monitor their performance to assist them in improving their practice by learning from the incidents.

The staff said they felt that significant events were being reported but no learning had arisen from these reports. We saw a number of incidents recorded with no process to make changes and monitor the changes to improve outcomes for patients. For example five incident reports referred to the fact that patients on warfarin had not had their blood taken for testing prior to a change in blood thinning medication being made. There were no actions or changes noted.

Reliable safety systems and processes including safeguarding

The practice had a system to manage and review risks to vulnerable children, young people and adults. However both the safeguarding policy for children and vulnerable adults were out of date and incomplete. The policies referred to primary care trusts (these are organisations which no longer exist) and did not have clear contacts from whom staff could seek advice if they needed it. The safeguarding children policy had a named safeguarding nurse but staff were unable to tell us who the person in the policy was and the person was not employed by the practice. The lead GP was the nominated lead for safeguarding and stated that they had completed all relevant training. Although some training certificates and attendance records were available in lead GP's staff file there was no information to show that they had completed the required level three training for safeguarding children.

We asked two other GPs at the practice about the practice's safeguarding arrangements. They informed us that they had undergone some training in safeguarding children and adults but there were no documented records of this. There was an information sheet which detailed how staff should deal with child safeguarding issues which was dated 2013. On enquiry, one GP showed us a Child and Adolescent

Are services safe?

Mental Health Services referral form on the computer system and told us this was used for routine referrals. They said they would contact the hospital on call paediatrician for advice if urgent. The information sheet documenting child safeguarding processes was not referred to.

We saw that there were posters in the treatment and consultation rooms that had relevant contacts for safeguarding and some guidance for staff to follow. When speaking to one of the GPs in their consulting room they stated that they were not aware of the safeguarding policy or guidelines.

Practice training records made available to us were confusing and difficult to review in that information was not clear as to who had completed what training. Information held in staff records and a separate folder contained some certificates of attendance for safeguarding training. The information showed that the majority of employed staff had received safeguarding training. When we spoke with staff they said they would raise any concerns with the lead GP.

There was a system to highlight vulnerable patients on the practice's electronic records. This enabled staff to prioritise appointments. Staff told us that these patients were always seen as soon as possible and that they ensured the GP was aware of any relevant information.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all staff, and they understood their responsibilities when acting as chaperones including where to stand when a patient was undergoing an examination. Reception and administrative staff undertook chaperone duties but has not undergone criminal records checks via the Disclosure and Baring Service. No risk assessments had been undertaken to support why the practice had taken this decision.

Patients' individual records were not written and managed in a way that promoted security of information. The majority of records were kept on an electronic system which collated all communications about patients, including scanned copies of communications from hospitals. However, we saw that original documents that had been scanned or were awaiting scanning were not stored securely which put them at risk of being lost or seen by unauthorised people. Confidential patient records which had been scanned were stored in the staff room and loosely packed into an open box where they could be seen by staff, contact cleaners and people visiting the practice. Patient records which had not been scanned were in closed boxes under a table. Results from various tests were in an open box on a low shelf and easily accessible to anyone who had access to the staff room, including contracted cleaners. Confidential patient records were also stored in a dedicated records storage room. In this room we found a number of paper patient files were loosely scattered on shelving units and easily accessible to cleaning contractors. No risk assessments were in place in relation to the storage of confidential patient records and information.

Patient records were not audited to assess whether they were complete or whether the quality of care provided met expected standards of care.

Medicines management

There was a clear process in place to check all medicines held in the practice were appropriate and in date. We saw evidence that regular checks were made to monitor the use of medicines and to ensure that they were in date.

There were clear guidelines to follow in relation to the storage of vaccines. The medicines fridge was secure and checked regularly to confirm that temperatures were maintained within the manufacturer's recommended range.

Prescriptions were stored safely and locked away when not in use. There was a process to monitor the use of manual prescription pads.

There was a protocol for repeat prescribing in that repeat and routine medications were issued by administrative staff and signed and checked by GPs. However, staff who generated prescriptions had no specific training in how to ensure that a repeat prescription was appropriate without further review by one of the GPs. In addition there was no statement in the protocol to stipulate that GPs should review repeat prescriptions to ensure that they were not being requested too frequently.

We saw that a number of patients who had been prescribed warfarin (a blood-thinning medicine) had not had required blood tests prior to repeat prescriptions being authorised by one GP.

Concerns were raised by staff in relation to prescribing practices. We were told that if administrative staff spoke to patients with a suspected urinary tract infection (UTI) then

they were expected to complete a prescription for a specified medicine and take this to the GP for signature. The prescription would then be given to the patient or care home. During our inspection we saw a memo on the reception notice board specifying this protocol was for patients in a care home. We were told that the prescriptions for the care home were now usually handled by the finance administrator who had taken the lead for the care home. We were told that there had not been any training or risk assessments to ensure that this process was safe. In addition, we were told by staff that the protocol did not only apply to residents of the care home, but to any patient who rang in with symptoms of a UTI. Administrative staff stated that they would write up the prescription and the GP would sign it. One of the administrative staff stated that in these circumstances they would always note in the computerised patient record that a telephone discussion had taken place with the patient and that the GP had prescribed the medicine. Other staff said they did not always record the telephone discussion.

Staff told us that the practice of the administrative/ reception staff writing up prescriptions as a result of a phone call had reduced with the exception of suspected UTIs for patients in the care home. However, administrative and reception staff were asked to write out prescriptions for other medicines. We were given examples of when administrative/reception staff had been told to write out prescriptions for eye drops for a baby, without the baby having been checked by a GP to ensure the prescription was safe or appropriate for the baby's condition. We were also told that at times patients were given a pack to take a swab of a baby's eye for themselves, when a swab should have been undertaken in consultation with a GP or a nurse.

The lead GP stated that administrative and reception staff could only write up prescriptions for residents of the care home and only after residents had a consultation with a GP. However, staff told us that they relied on the results of 'urine dipstick analysis' carried out by care home staff to confirm that a UTI had been diagnosed. The lead GP stated that none of the administrative and reception staff had received any specific training for carrying out this role.

Overall, there was conflicting information regarding whether prescriptions were issued and authorised by a GP and whether prescriptions were provided as a result of clinical assessment. Some staff reported certain medicines were being prescribed without any contact with the GP, whereas GPs maintained that all medicines were prescribed after clinical assessment. Two of the patients we spoke with said that they had telephoned the surgery and then came in later to collect a prescription for an infection.

Staffing and recruitment

We looked at all of the staff files and found that they were incomplete. For example, there was no evidence of criminal records checks via the Disclosure and Barring Service for a number of staff. Hepatitis B immunisation checks, photographic identification, professional indemnity and evidence of qualifications were found to be missing. There was no evidence of induction being provided or documented for new staff. There was evidence of a standard employment contract used for a salaried GP, as well as a subsequent employment review towards the end of the probation period.

There was no risk assessment in place as to why the practice had not undertaken criminal records checks via the Disclosure and Barring Service for administrative staff, many of whom undertook chaperone duties.

Locums were regularly used and there was no evidence of a service level agreement to ensure that they had the relevant training and checks in place prior to employment.

Most of the employment contracts for staff related to the previous practice owners and they had not been changed or updated to show that they were now employed by a different person. There was no documented process for the employment of new staff.

Staff told us that there was no clear arrangement for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were told that there was no practice manager as the previous one had left in June 2014 and the practice did not have the funds to employ a new one. We saw this recorded in minutes from a staff meeting. Reception/administrative staff told us that they often felt overwhelmed and were expected to manage an excessive workload with little or no support from management.

One GP stated that the work was too much for the GPs available and this led to complaints and frustration for both the staff and patients. Staff told us that there were not usually enough staff to maintain the smooth running of the practice or to ensure patients were kept safe.

Are services safe?

In addition to providing services to the registered practice population, the practice also exclusively provided care for two large nursing homes. Staff told us this added extra work onto an already stretched service. We were told the practice had been depending on locum GPs to cover gaps in provision of care but this had not always been sufficient.

Monitoring safety and responding to risk

We looked at the systems for managing medicines that were held in the practice for medical emergencies. We checked the medicines and found they were within their usable date. We found emergency medicines stored in a box in a cupboard that was easily accessible to staff. The practice had medical oxygen and an automated external defibrillator (AED) for use in an emergency. There were records kept to show when these had been checked and the practice was able to identify when/what medicines had been used and when the stocks had been replenished.

The practice did not have clear robust systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There were no checks of the environment and staffing. Although the practice had a health and safety policy and some health and safety information was displayed for staff to see, the nominated lead for health and safety stated that they had not received any training and did not carry out any risk assessments.

We were told by staff that when some risks had been highlighted, for example the risk of patient falls when leaves collected outside the practice leading to an increased risk of falls, their concerns were dismissed and they were told to address the issue themselves. Staff said that when they had raised concerns about boxes on the floor being a trip hazard, their concerns were ignored. We saw that there had been no risk assessments carried out since the change of ownership of the practice.

There was no forum to discuss any risks or actions to improve the safety of the practice for patients or staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could not clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance in some but not all instances.

For example, we saw that treatment for those patients on warfarin did not always follow best practice guidelines as prescriptions were changed without the appropriate blood tests taking place. There had been no training or support for the GP when the practice nurse was unwell; therefore they were unaware of the processes that they should follow in relation to checking blood results for these patients.

GPs in the practice undertook minor surgical procedures in line with their registration. However, there was no evidence to demonstrate they followed any relevant professional guidance or whether they had been appropriately trained and kept up to date.

Staff told us they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However, there was no practice wide approach as to how guidelines should be shared between staff or consideration of the impact of these on individuals' practice. Each of the staff appeared to be acting in isolation with no agreed strategy for sharing information or ensuring continuity of care. This was supported by the patients we spoke with who stated that they did not think staff in the practice spoke to each other.

We were told by staff that there were no practice meetings to discuss patient care or how to ensure that patients received coordinated care form all members of the practice staff.

The practice did not use a formal triage system to manage its referrals to specialities or secondary care. We were told individual GPs referred as they felt necessary.

Specific clinical roles were not delegated to GPs in the practice. Instead, the lead GP led in all clinical areas. There was no opportunity for sharing or learning and not all patients were seen by the lead GP, meaning that there was no consistency of care.

There was no clear leadership to support the practice in achieving clinical Quality and Outcomes Framework (QOF) outcomes. Instead, performance against the QoF outcomes was left to individual GPs and nurses. For example, chronic disease monitoring was undertaken by the practice nurse with clinical input from GPs on prescribing. However, no audits or correlation of information was available to show how this approach worked to support patients and to ensure that care was appropriate.

Management, monitoring and improving outcomes for people

The practice did not use information for monitoring and improving outcomes for patients. There was no clinical audit programme to monitor and evaluate the quality of services provided to patients. There were no records of staff meetings that showed discussion about patient care.

Staff told us they did not feel included in decision making. One GP stated that they had completed an audit in diabetes management which was discussed in an annual professional appraisal but there was no documentation to support when this had been done. Another GP and the lead GP told us they had not completed any clinical audits during the last 12 months. There was no plan in place for new audit activity.

Effective staffing

We reviewed staff training records and saw that most staff were up to date with basic life support training and had received annual updates. There was no evidence of GPs having additional diplomas or qualifications in specific aspects of clinical care, although they carried out minor surgery in the practice.

Although we were told that GPs were up to date with their yearly continuing professional development requirements and revalidations, there was no documentary evidence to support this.

Staff stated that they had not received annual appraisals to identify progress and learning needs. Although some training had taken place such as safeguarding, customer relations, dealing with challenging people and basic life support, staff stated that the practice was not proactive in providing training for development and there was no opportunity to undertake any training that was not specified by the lead GP.

Are services effective?

(for example, treatment is effective)

The practice nurse and healthcare assistant had defined duties they were expected to perform and had received some training to fulfil these duties. For example, administration of vaccines and cervical screening.

There was no evidence of induction being provided for new staff. The last clinical/education training course, which was basic life support, was held in February 2014 and no further training was recorded. GPs confirmed there was no further training planned. GPs and nurses were not aware of further plans for clinical/education meetings in the near future, nor were there any needs assessments done in this area.

Administrative staff had received training in relation to customer service but they all stated that there was no clear plan in place to support their development. Some felt that they had not received the training they needed to carry out nominated functions. For example, leading on health and safety.

All staff spoken with stated that the former practice manager had some training plans in place but this had not been addressed since their departure. Staff did not feel supported in their roles or able to ask questions when they needed to do so. Most staff said that they did not feel equipped to do what was expected of them.

Working with colleagues and other services

We spoke with a visiting district nurse who was employed by the local NHS trust to support people with long term conditions, in order to reduce their admissions to hospital. They said they met with the GPs regularly to discuss patients with serious illness and fed back any relevant information to them from the hospital or district nursing team.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013 national patient survey and a 2014 survey of patients undertaken by the practice. The evidence from all these sources showed patients were not satisfied with how they were treated. For example, data from the national patient survey showed the practice was rated 'among the worst' for patients rating the practice as good or very good. The practice was also 'among the worst' for opening hours and recommending the practice. The practice survey reflected similar findings and showed that 7% of respondents would refer the surgery to a friend and 43% would not. Others had chosen not to respond to the question.

We spoke with 13 patients on the day of our inspection and 11 of them said that they felt the service offered by the practice had deteriorated in the last 12 to 18 months. They said that although the receptionists were usually helpful and caring, when they were stressed they could be abrupt. All but one said that they were not satisfied with the care provided by the practice although they felt that their privacy was respected. As a group, patients did not feel it was dignified to stand outside in all weathers to try and book an appointment when they were already unwell. The majority of patients also stated that they did not feel listened to by the GPs and that they felt rushed through their appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed, showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice poorly in these areas.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them by the nursing staff and all but one felt involved in decision making about the care and treatment they received. However, they told us that the GPs were usually very rushed, they saw a different GP every time, and they were not listened to. Patients who had been given a prescription told us they were given prescriptions with little or no discussion about their symptoms or concerns. They also told us they did not feel listened to and supported by GPs and that usually there was insufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

The practice had a system to flag up when a patient was a carer even if the person they cared for was registered with another practice. There were a number of leaflets and notices on a notice board in the waiting room for carers, to enable them to access additional support and advice.

There were leaflets and notices on the notices board for accessing support groups and additional services for patients. We were told by practice staff that they would give additional information to patients if they needed it to ensure that they could contact others for support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff told us the practice had tried to recruit volunteers to a patient participation group (PPG) but the response had been poor. We saw advertisements for the PPG on the notice board in the waiting room as well as on the practice website. The three sets of PPG meeting minutes we saw recorded discussion of individual issues rather than concerns impacting on the whole practice. On two occasions only four people were present, two of whom were practice staff. As a result of one meeting the practice had adhered a note to the 'repeat prescription box' stating that comments could be posted as well. Three of the patients we spoke with were concerned that this method of obtaining feedback would confuse the prescriptions process, they suggested a separate box should be installed.

The 2014 practice survey highlighted patients concerns' and dissatisfaction with the appointment system. The practice had not taken action to address this. The only reference to these concerns was contained within the practice's patient leaflet, which stated that if patients needed to be seen urgently, they should attend the 'drop in clinics' or make appointments for routine consultations in advance. Patients we spoke to said that the system did not work and they had to wait up to a month for an appointment after receiving a letter asking them to come in for results. We also saw a memo to staff on how they needed to 'educate' patients about the correct use of the 'drop in clinic'.

There were no systems in place to assess and evaluate the needs of the practice population and to ensure these were understood, therefore services were not planned around the needs of the practice population.

All patients over 75 had a named GP. However, patients said there were delays in obtaining routine appointments with their named GP. Two patients stated that they would see whichever GP was available because otherwise they might not get an appointment at all.

Access to the service

The practice had what it called a 'drop in' clinic every morning from 8:30am to 9:30am and booked appointments from 3pm to 6pm on weekdays, with further appointments from 6:30pm to 7:30 pm on Monday and Thursday.

Staff told us that the 'drop in' clinic was for patients to come in person to the practice and make an appointment to see a GP in the morning. We were told that patients who had come in prior to 9:30am were guaranteed to be seen by a GP. Patients we spoke confirmed that if they were willing to queue they were usually seen. We were told that the GPs then started to see patients from 9:30am. However, the appointments screen showed that some patients were seen from 8:30am. This still meant that a number of patients were given GP appointments for later in the morning which required them to go home or back to work and return at a later time. All of the patients we spoke with complained about this system and felt t this was not a helpful way of booking in. We spoke to patients with young children who found this process very stressful. One patient told us of her experiences of waiting in the rain with their children, in order to get an appointment for later in the morning. The patient told us that they and the children had been so wet from standing in the rain that they had returned home, put the children in dry clothing and then arranged child care so as not to get the children wet again whilst she returned to the practice by which point they stated, they were feeling very unwell.

On the day of our visit, before 8am, we observed a long queue of people standing in the rain waiting for the practice doors to open. Whilst sitting in the reception area we saw that a number of people came back to the practice for appointments but had to wait for up to 25 minutes as the appointments prior to them had overran. Although we saw that a memo had been sent to staff asking them to let patients know if there was going to be a delay of over 20 minutes, there were no announcements made during our visit.

Patients were told that the 'drop in clinic' was for urgent cases and that they could book routine appointments for up to two weeks in advance. Patients told us that it was virtually impossible to get through on the telephone between 9:30am and 12pm as the lines were constantly engaged. As the practice was closed between 12pm and 3pm, people who were working found these times very restrictive. The practice introduced extended opening hours on Mondays and Thursdays from 6:30pm to 7:30pm but patients told us they still found it very difficult to book appointments.

Staff we spoke with expressed frustration with the appointment system and recognised the impact it had on

Are services responsive to people's needs?

(for example, to feedback?)

patients. We were told that if a patient telephoned the practice before 9:30am for an appointment, they would be asked if there was anyone who could come to the practice and queue for an appointment for them. If they did not have anyone to come and the receptionist felt that the matter was serious they would attempt to speak to the GP, to either make an appointment or arrange a call. Staff told us that in the majority of cases they were asked to tell the patient to book a routine appointment or, on occasion, the GP would ring them to assess whether they needed to be seen that day or required a home visit. Administrative staff felt pressurised to encourage people to come into the practice because of concerns that making an appointment on the phone for one person might be seen as a precedent for others to do the same.

Any patients ringing in for a home visit would have their records called up and a notation made for the GP to ring them back to assess the need for a home visit. Administrative staff did not make decisions about home visits.

Patients were able to book appointments with the nurse directly or make a further appointment at the end of their consultation. We were told by a member of the nursing staff that the practice nursing staff ran the vaccination/ immunisation clinics but that the practice policy was that a GP was required to be on site during these clinics in case of any untoward reaction. We were told that on some occasions the nurses had to cancel some appointments towards the end of these clinics, as the lead GP had left the premises and they were told it would be unsafe for them to give vaccinations.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. We saw that the complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. This was the lead GP. The information available to patients contained contact details for how they could escalate complaints if they felt that their complaint had not been adequately dealt with.

We looked at the complaints folder and found that there had been 14 written complaints since April 2014. All complainants had received a letter acknowledging their complaint in a timely manner. However, there was little information as to what actions had been taken in response to the complaints and how the issues raised had been addressed by the practice. In the majority of circumstances the practice sent an apology to the complainant but no further investigation or action was taken. In one complaint, we saw on-going correspondence from July 2014 and no resolution. When we asked about how complaints were reviewed we were told the lead GP looked at them and then a letter was sent to the complainant. There was no investigation or analysis of complaints and lessons from complaints were not identified. We found an annual aggregated report about complaints from 2011 when the practice was owned by another provider; however, there were no similar analyses of complaints since then. Staff told us that complaints were not discussed within the practice and were not viewed as a tool to learn from.

The practice had a whistle blowing policy which was available to all staff on the intranet, however this did not follow up to date guidance. It made reference to out of date initiatives and to organisations which no longer existed, for example 'Standards for Better Health' and primary care trusts. There were no external agency contact details and the policy specified that the staff member raising concerns had to do so in writing via the practice. This is not in line with the national guidance from ACAS (an agency who provide information, advice, training, conciliation and other services for employers and employees to help prevent or resolve workplace problems). The majority of staff said that they were anxious about raising a concern and that they welcomed the inspection but were concerned about the ramifications of the report.

We saw that there had been a number of negative comments on the NHS Choices Website and the practice had failed to respond to them.

Are services well-led?

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

Our findings

Vision and strategy

The practice did not have a documented vision or strategy. When we spoke with staff they were unable to say what the vision of the practice was or how they would achieve better quality for patients.

Governance arrangements

There was no specified governance framework and staff were unclear about their roles and responsibilities in relation to the running of the practice. Although we saw notes from one meeting that specified certain activities for some of the administrative staff, we were told that these had never been fully discussed or agreed. Some staff felt unsure of what was expected of them and stated that they just did as they were told. They said that their job descriptions had not been updated in line with changes made by the lead GP since they took over the practice.

There were no comprehensive assurance systems, performance measures or monitoring of services to improve performance.

There was no programme of clinical or internal audit to monitor quality and identify where action should be taken to improve services.

No risk assessments had been carried out to enable the practice to reduce any identified risks.

Leadership, openness and transparency

Staff we spoke with said that they did not feel included in any decision making within the practice. Most said that they felt that the lead GP was too busy to be disturbed. They felt that there were barriers to raising concerns where previously, before the change of ownership, there had been a very open culture. Staff said they did not feel fully equipped to deal with all that was expected of them and were afraid of raising concerns as they would then be seen as unable to do their job.

There were no delegated responsibilities to the salaried GP and the lead GP made all decisions relating to the running of the practice. There were no opportunities for shared learning or development for the salaried GP.

Staff and patients that we spoke with said that the culture was no longer based on the needs and experience of the patients. They said it was now just what the lead GP said with no consultation or consideration of individual needs.

We could not see any clear priorities for the leadership and there was no development strategy for staff.

There were no specific clinical meetings to discuss patients' needs. The notes of the meetings we saw related to the performance of one member of staff. Staff said they felt unsupported and that there was a blame culture within the practice. Staff also said they welcomed the Care Quality Commission inspection team but were concerned about the repercussions following the inspection. Staff expressed concerns that the culture within the practice did not encourage challenge, candour, openness or honesty.

None of the GPs we spoke with raised the issue of external peer review and there were no processes in place for GPs to review each other to encourage learning and development.

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

Attempts had been made to develop the patient participation group (PPG). The group had met three times and attendance was poor. When asked, most of the staff stated that they were unaware of what actions had been taken to increase membership of the PPG. One staff member said they were aware that the practice had advertised and had difficulty in recruiting members.

We saw that the practice had carried out a patient survey in 2014 but that no action plan was in place to address the concerns.

There was a note on the repeat prescription box asking patients for comments but all of the patients we spoke with said that they would not bother, as they had raised issues before and no action had been taken to address their concerns.

Staff did not feel engaged and did not feel listened to. Staff were not encouraged to raise concerns and were worried that they would be viewed as trouble makers if they challenged any decisions that were made.

Management lead through learning and improvement

Staff told us that the practice did not actively support them to maintain their clinical professional development. When we spoke to GPs, nursing and administrative staff we were

Are services well-led?

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

told that there were some learning events to cover fundamental training needs such as basic life support but that they were not encouraged to seek out other learning opportunities. We looked at all of the staff files and saw no appraisals had taken place in the last year and there were no personal development plans.

There were no practice or staff meetings to enable staff to share information and learn from each other, or from feedback following untoward events or complaints.

There was no evidence that the practice used information to improve the quality of services provided.