Dr Alan M Campion

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. The practice was previously inspected on 28 April 2015 when the practice was rated as good overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – requires improvement

Are services caring? – requires improvement

Are services responsive? – requires improvement

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The concerns raised in Safe Caring and Well Led affect all of the population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those recently retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

People experiencing poor mental health (including people with dementia) - Inadequate

We carried out an announced comprehensive at Dr Alan M Campion on 9 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had not taken action to assess or mitigate risks associated with fire, infection control legionella or health and safety.
- Safeguarding policies were not practice specific, non-clinical staff had not received safeguarding training and not all staff were chaperoning in accordance with current legislation and guidance.
- There was limited evidence of learning from significant events and no policy in place. The complaints process also did not function effectively.
- There was no evidence that the practice was taking action in response to patient safety alerts in accordance with their policy and there was no effective system in place for monitoring urgent diagnostic referrals.
- Medicines were not managed effectively. The practice could not locate Patient Group Directions (PGDs) for nursing staff and we found two expired medicines in the practice fridges.

Summary of findings

- Not all staff had undertaken the required training and systems for recruitment and appraisals were ineffective or non-existent.
- The care plans we reviewed indicated that the practice was delivering treatment in accordance with current guidelines and best practice and we saw some evidence of worked which aimed to improve the quality of care provision. However, the practice achieved lower than the local and national averages in respect of a number of clinical and public health indicators. There was limited evidence of action taken to review below average performance and make improvements.
- Feedback from patients on the day of the inspection indicated that staff treated patients with compassion, kindness, dignity and respect. However, national patient survey scores showed the practice performed below local and national averages in respect of its GP consultations and satisfaction with reception staff.
- Most patients spoken to on the day of the inspection found the appointment system easy to use and reported that they were able to access care when they needed it. However, some patients told us that they had to wait a long time to be seen when they arrived for their appointment. The national patient survey showed the practice scored lower than others on questions related to access.
- Practice policies were not effective. Some policies were from other services and/or did not contain required information on leadership and governance arrangements. There was no evidence of internal meetings having taken place since January 2016.

The areas where the provider **must** make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- 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.

The areas where the provider **should** make improvements are:

- Consider ways to highlight bereavement and translation services.
- Continue with planned work to upgrade the practice premises.

I am placing this service in special measures. Services placed in special measures will be reinspected after a period of six months.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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

Dr Alan M Campion

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and an expert by experience.

Background to Dr Alan M Campion

Dr Alan M Campion is part of Southwark CCG and serves 5200 patients. The practice is registered with the CQC for the following regulated activities Diagnostic and screening procedures; Treatment of disease, disorder or injury; Maternity and midwifery services.

The practice is located within an area ranked on the third least deprived decile on the index of multiple deprivation. The area has a high level of unemployment compared to the local and national average. The patient list consists of a lower proportion of older people and children compared to other areas in the country and a significantly higher proportion of working patients.

The practice is run by Dr Alan Campion. There is a salaried GP and a long term locum. Doctors at the practice collective provide 16 sessions per week. There is a part time practice nurse working 35 hours per week, another nurse (currently absent) who works 37.5 hours per week and a full time healthcare assistant. The practice has employed locum nursing cover for 8 hours per week while the nurse was absent. The practice is a teaching practice for final year medical students.

We were told by staff that the practice manager worked in the practice between one and two days per month. This staff member dealt with financing, staff recruitment and engagement with external partners including NHS England and the CCG. Managerial responsibilities were divided between other members of staff including some employed through the federation, the patient services manager and the practice nurse.

The practice opens at 7.30 am Monday to Friday. The practice closes at 8pm on Monday and Tuesday and 6.30 pm the rest of the week.

The Dr Alan M Campion service operates from New Mill Street Surgery, London, Southwark, SE12BP which is a property rented from a private landlord. The premises are not suited to accommodating persons with disabilities but we were told that the practice had obtained an improvement grant to make appropriate adjustments.

Practice patients are directed to contact the local out of hours provider when the surgery is closed.

The practice operates under a Personal Medical Services (PMS) contract, and is 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 are: Childhood Vaccination and Immunisation Scheme, Extended Hours Access, Facilitating Timely Diagnosis and Support for People with Dementia, Influenza and Pneumococcal Immunisations, Learning Disabilities, Patient Participation, Rotavirus and Shingles Immunisation, Services for Violent Patients, Unplanned Admissions.

The practice part of a GP federation Quay Health Solutions.

Inadequate

Are services safe?

Our findings

The practice was rated as inadequate for providing safe services.

Safety systems and processes

The practice did not have a clear system to ensure patients were safe or safeguarded from abuse.

- The systems in place to safeguard children and vulnerable adults from abuse were not specific to the practice. For example the child safeguarding policy stated that the staff responsible for record keeping was a person unknown to the practice. The adult safeguarding policy related to safeguarding for the local extended primary care service. The practice provided updated policies after our inspection but the adult safeguarding policy did not explicitly state who the practice lead was.
- We saw several instances where the practice had raised concerns with other agencies to support patients and protect them from neglect and abuse. The practice said that they did not have regular meetings with the health visitor and there was no documented evidence of meetings taking place. We were told this was due to a lack of availability among the health visitor team within the locality.
- The practice had not carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks had not been undertaken for two members of clinical staff; though we saw that these were requested on 8 November 2017. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The medical indemnity on file for one of the locum GPs had expired and there was no evidence of indemnity insurance for the locum nursing staff though we were told after the inspection indemnity cover would be provided by the nurse's unions.
- Not all staff had received up-to-date safeguarding and safety training appropriate to their role. None of the non-clinical staff had any safeguarding training. All staff spoken to said they were alert to signs of abuse and knew how to report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check; however, one staff member told us that they would only stand within the curtain so they could see the examination if a clinician requested them to do so. The practice's chaperone policy was from another organisation.
- The practice ensured that clinical equipment and electrical equipment were safe and regularly tested. There were systems for safely managing healthcare waste.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were ineffective.

- The arrangements in place for planning and monitoring the number and mix of staff needed did not ensure sufficient staff were employed to provide effective managerial oversight of the practice and provide sufficient nursing time. We were told that the practice manager only attended the practice once or twice per month. A list provided showed the division of managerial responsibility within the practice but it was evident that this was not effective. For example, despite asking the people designated as responsible for this area, we were unable to find recruitment files for all staff members on the day ofthe inspection. The practice's recruitment policy was from another practice.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections. For example we were given an example of how staff responded to a patient who presented with sepsis. However, from looking at records the practice's emergency equipment was not being reviewed consistently.
- It was evident that the impact to staffing changes was either not fully assessed or addressed. We were told that the practice manager had not been working full time at the practice for a number of years and it was evident that in a number of key areas there was a lack of managerial control. The practice produced a document which reviewed a number of inefficiencies and it was apparent that the impact of not having effective management was known but had not been addressed. The practice employed two nurses. We were told that

one of the full time nurses was on sick leave at the time of our inspection. The remaining nurse was assisted by a locum nurse who provided eight hours of nursing time per week. The locum nurse was the only nurse who administered childhood immunisations. In spite of a reduction in nursing hours the practice nurse had been tasked with being the lead for both complaints and significant events and accepted that they were not able to effectively oversee these areas due to the practice nursing commitments.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients yet there was no clear failsafe system in place for urgent referrals.

- Referral letters included all of the necessary information. However, there was no systematic approach to checking that a patient had attended secondary care for urgent diagnostics.
- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Safe and appropriate use of medicines

The systems in place did not ensure that medicines were handled safely.

- Prescription stationery was kept securely and there was a system for monitoring the collection of controlled drug prescriptions. However, there was no log to monitor the use of other prescriptions. Uncollected prescriptions were not checked with sufficient frequency. Reception staff told us that uncollected prescriptions would be checked every two to three months. We found a number of uncollected prescriptions dating back to August 2017.
- The systems in place to monitor vaccines in the practice were not effective as we found expired vitamin K and meningococcal vaccines which had expired in October 2017. We were told that the vitamin K was the responsibility of the visiting midwifery team.
- Staff at the practice were unable to locate Patient Group Directions (PGDs) for the practice nurse and the many of the ones provided for the locum nurse had expired. We were told that staff had sight of these prior to the inspection but they could not find them. We were provided with up to date PGDs for the salaried nurse after the inspection but did not receive those for the locum nurse.
- Practice prescribing of quinolones and cephalosporins was twice the national average.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship; for example, an audit undertaken with the local medicines management team regarding the prescribing of antibiotics for urinary tract infections. The first cycle of the audit showed that the practice had not met the 90% compliance standard across three criteria. However, the information provided indicated that this was because of the high proportion of patients who required antibiotics for lower urinary tract infections. The practice considered longer courses and different antibiotics to be more effective in treating these infections. The lead GP had contacted a professor who run specialist clinics for the treatment of urinary tract infections for further advice in this area.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice did not have safety systems in place to manage risk.

- The practice produced a fire safety risk assessment. This was on a single sheet of paper and was not comprehensive, not dated and did not include an action plan to address the risk identified. We saw evidence of an email from an external organisation who confirmed that they would undertake a range of risk assessments including fire safety and legionella on 15 November 2017. The practice did not have a significant event policy and other policies contained incorrect information. For example we were told that the nurse was the infection

control lead by most members of staff, though the nurse herself was uncertain if she fulfilled this role and was not actively undertaking infection control leadership duties. The policy for infection control stated responsibility was split between the lead GP and the practice manager. Staff were working to different infection control policies. No infection control audit had been undertaken in at least the last 12 months.We saw evidence that the practice had instructed an external company to undertake a range of risk assessments, including legionella and fire safety, on 15 September 2017 and were provided with copies of these after our inspection which included action plans. There was no evidence of fire drills, no fire policy and we were told that staff did not know how to test the fire alarm which only covered the second floor of the premises.

Lessons learned and improvements made

Learning from significant events was not clear though we saw example of improvements made in response to one event and there was no clear system in place for acting on patient safety alerts that staff could tell us about on the day of the inspection.

- There was no policy in place for the management of significant events. There was a recording form available and some staff knew where to access this but we were informed by one of the GPs that this form was not always used and noted that other events had been recorded using different means. It was unclear who was responsible for documenting significant events from discussions with staff. The lead for significant events told us that they were trying to get staff to document events they identified. One staff member was unclear as to what constituted a significant event and said they were not involved in significant event management. All other staff we spoke with were aware of one recent event but only some staff could outline action taken or the learning from this. One of the clinical staff members was able to identify a significant event regarding an allergic reaction to medication and concerns were shared with the local medicines management team. Reference to discussion regarding significant events was recorded on the significant event forms.
- There were no minutes from meetings where significant events were discussed and learning shared. We were told of one incident related to childhood immunisations which resulted in the practice's new patient form being updated.
- The practice had a policy for reviewing patient safety alerts. The policy stated that these should be discussed and action taken and documented. There was a safety alert log on the practice's computer system. This only had one patient safety alert noted from January 2017. One clinical staff member could outline action taken in response to a recent medicines alert. This was not noted on the safety alert log and there were no other alerts recorded as having been reviewed or action taken. We were told by staff that alerts were managed by a pharmacist employed by the federation. We were provided with an alert monitoring spreadsheet from the federation after the inspection. This did not contain information about action taken in response to alerts but only confirmed that the practice had either acknowledged receipt of the alert or that the alert did not apply to the practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as requires improvement for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance. However, practice specific clinical pathways and protocols were lacking in respect of the management of pathology results and letters and urgent referrals. There was no evidence of updates to guidance being discussed in clinical meetings.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The percentage of antibiotic items prescribed that are cephalosporins or quinolones was 10% compared with 4% in the CCG and 5% nationally.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used a clinical system which aimed to ensure compliance with the latest prescribing guidelines and that patients were placed on appropriate referral pathways. The practice also made use of an app which enabled them to access advice from consultants. Virtual clinics were held for a number of long term conditions. These were supported by consultants from local secondary care services who aimed to ensure that care and treatment for patient with complex long term conditions was optimised.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice participated in a holistic health assessment scheme for patients who were over 80, over 65 who had not attended the GP in some time or who had comorbidities or frailties. Patients were provided with a full assessment of their physical, mental and social needs. Care plans were drafted and referrals were made to relevant health and social care organisations. Those identified as being frail had a clinical review including a review of medication. The practice delivered eight assessments at home and 51 within the practice in the last year.
- The practice administered influenza immunisations to 76% of patients over 65.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- The practice had achieved their locality targets for diabetes and were the second best performing practice for diabetes within the CCG in 2016/17.
- Patients with other long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, the percentage of patients with COPD who had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 77% compared with the local average 91% and the national average of 90%. The exception reporting rate for this indicator was 2% compared with 3% in the CCG and 9% nationally.
- The practice had fitted 25 ambulatory blood pressure monitors in 2016/17.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below with the target percentage of 90% for children under 1 receiving the full course of recommended vaccines (80%), children aged two who had received the pneumococcal conjugate booster vaccine (86%) and children aged two with Haemophilus influenza type b and Meningitis C booster vaccines (86%). The practice told us that this was due to patients having vaccines administered privately or being unwilling to vaccinate their child due to concerns

around the MMR vaccine. Childhood immunisations were usually administered by a staff member currently on long term sick leave. Only the locum nurse working eight hours per week currently administered childhood immunisations. However the practice could refer children to the local extended access hub to have immunisations administered.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 68%, which was below the 80% coverage target for the national screening programme. We were told that the lower than average rate of cervical screening was as a result of a reduction in nursing staff, and that many patients have screening done privately but then do not inform the practice of the results. The practice told us that they had undertaken a text message campaign to recall all women who had not attended for screening and offered these women weekend appointments at the extended access hub.
- The practice had systems to inform eligible patients to have the meningitis vaccine.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had undertaken 216 health checks in the last year.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

People experiencing poor mental health (including people with dementia):

- The practice had undertaken screening for 157 patients at risk of dementia in the previous year.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 88% compared with the local 84% and the national average of 84% nationally. However, the exception reporting rate was 33% compared with the local average 5% and the national average of 7%. The practice was unable to account for this.
- 87% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the national average of 90%. Exception reporting was 2.6%, lower than the national average of 12.5%.
- The practice considered the physical health needs of patients with poor mental health and those living with dementia. Though the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was lower than the local and national average (68% compared with 91% in the CCG and 91% nationally), the practice had not exception reported any patient under this criteria compared to 6% in the CCG and 10% nationally.

Monitoring care and treatment

The practice had a programme of quality improvement activity and we saw some limited evidence of quality improvement. Where appropriate, clinicians took part in local and national improvement initiatives including local prescribing audits.

The most recent published Quality Outcome Framework (QOF) results were 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 96%. The overall exception reporting rate was 4.4% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

The practice performed well in respect of management of blood pressure in patients with diabetes with 91% of these patients having well controlled blood pressure compared to the local average of 77% and the national average of 78%. The practice provided a list of indicators which showed that their performance for diabetic indicators was the second highest within the CCG.

Requires improvement

Are services effective?

(for example, treatment is effective)

However the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months was 68% compared with 91% in the CCG and 91% nationally. The practice had not exception reported any patient under this criteria compared to 6% in the CCG and 10% nationally. The practice attributed this to a problem with coding though this was not support with any analysis.

The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 77% compared with the local average 91% and the national average of 90%. The exception reporting rate for this indicator was 2% compared with 3% in the CCG and 9% nationally. The practice told that a large number of their patients refused to come into the practice for their annual review and some patients have been seen in secondary care but not had their score on the dyspnoea scale recorded. The practice told us that they had discussed these concerns during a virtual clinic with the local hospital.

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 88% compared with the local 84% and the national average of 84% nationally. However, the exception reporting rate was 33% compared with the local average 5% and the national average of 7%. Again the practice could not explain why performance in this area deviated from the local and national averages. The practice informed us after the inspection that they had 12 patients with dementia and four of these patients in total had been exception reported. Three of these patients were exception reported on the basis that the date of diagnosis was within the last three months.

The practice performed in line with other practice for all other QOF indicators.

The practice used information about care and treatment to make improvements.

- An audit was undertaken of patients with chronic obstructive pulmonary disease (COPD) with a view to improving the quality of reviews of these patients. The audit demonstrated some improvement in two areas. The number of patients prescribed a metered dose inhaler who had also been issued a spacer (device which assists medicine from inhalers to reach the lungs) increased from 23% at the first cycle to 28% in the second cycle. The percentage of patients who had a check of their inhaler technique increased from 25% to 42%. The practice participated in virtual clinics which reviewed patients with atrial fibrillation who were not prescribed anticoagulant medicine. Of the 17 patients reviewed an additional four patients were prescribed an anticoagulant. The rest of the patients either refused intervention or were not suitable for anticoagulation.

Effective staffing

Staff had the clinical skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisations and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. However, some essential training had not been completed.

- Though there was evidence of clinical updates being undertaken, for example in respect of the management of long term conditions, there were gaps in essential training. For example no non-clinical staff member had completed basic life support training within the last 12 months. All of the non-clinical staff whose files we reviewed had no record of safeguarding training and the training matrix provided by the practice indicated that no non-clinical staff had received this training. Non-clinical staff whose files we reviewed had either not completed any information governance training or this had not been done within the last 12 months. This corresponded with the information in the training matrix provided.
- All staff we spoke with said that the leadership within the practice was supportive and staff were allowed to attend any training that they requested. However, there was no evidence of an induction process or regular one-to-one meetings and appraisals.
- We were told that coaching and mentoring, clinical supervision and support for revalidation were offered.
- The healthcare assistant had the requisite training which included the requirements of the Care Certificate.
- Due to a lack of effective leadership around staffing and recruitment there was no clear approach for supporting and managing staff when their performance was poor or variable.

Requires improvement

Are services effective?

(for example, treatment is effective)

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, alcohol risk reduction.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Requires improvement

Are services caring?

Our findings

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

Kindness, respect and compassion

From what we saw on inspection and the feedback from staff and patients on the inspection staff treated patients with kindness, respect and compassion. However national patient survey scores were lower than local and national averages in some respects.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.
- All of the 27 patient Care Quality Commission comment cards we received were positive about the care provided and said that clinicians provided compassionate care. Five comment cards contained mixed feedback and one card only negative feedback. Negative feedback related to waiting times for appointments.

Results from the July 2017 annual national GP patient survey showed patients rated the practice below local and national averages for scores related to consultations with GPs. Three hundred and sixty surveys were sent out and 110 were returned. This represented about 2% of the practice population. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 75% of patients who responded 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%.
- 71% of patients who responded said the GP gave them enough time; CCG - 82%; national average - 86%.
- 86% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 94%; national average - 95%.
- 63% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 82%; national average - 86%.
- 86% of patients who responded said the nurse was good at listening to them; (CCG) - 85%; national average - 91%.
- 93% of patients who responded said the nurse gave them enough time; CCG - 87%; national average - 92%.
- 82% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 94%; national average - 97%.
- 85% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 85%; national average - 91%.
- 58% of patients who responded said they found the receptionists at the practice helpful; CCG - 85%; national average - 87%.

The practice attributed the lower than average scores to a lack of clinical time. It was hoped that having recently taken on a long term locum would improve access and enable clinicians to build rapport with patients. The practice had introduced telephone consultations which they hoped would improve GP access and continuity.

In order to address lower than average satisfaction with reception staff the practice told us that they had updated job descriptions with a set of competencies that every staff member would now be working to, staff would hold regular reception meetings and staff would have customer care training. However, we could not locate job descriptions for staff whose files we reviewed and there were no minutes from meetings of reception staff.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language. However, there were no notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Practice staff spoke French, Spanish, Italian, Polish, Hindi and Urdu.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. The practice did not have a hearing loop but told us that they would purchase one with the money from a recently obtained improvement grant.

Requires improvement

Are services caring?

- Staff helped patients and their carers find further information and access community and advocacy services. The practice had trained a number of reception staff as primary care navigators who could refer vulnerable patients or those with caring responsibilities to local advocacy and support services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 81 patients as carers (2% of the practice list). Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card or letter. This was either followed by a patient consultation at a flexible time and location to meet the family's needs or a referral to a local support service. The practice has trained two members of reception staff as primary care navigators who could direct patients to local charities and services for bereavement support.However there was no information about local bereavement services in the waiting area.

Results from the national GP patient survey showed patients' responses to questions about their involvement in planning and making decisions about their care and treatment were lower than other practices locally and nationally in respect of GP consultations:

- 72% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 83% and the national average of 86%.
- 63% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 77%; national average - 82%.
- 90% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 84%; national average - 90%.
- 79% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 79%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. However the premises were not easily accessible in some areas for patients who used a wheelchair and there were no designated baby changing facilities.

- The practice had taken action in response to feedback from its population and tailored services in response to those needs. (For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.) Patient survey results indicated that some patients were dissatisfied with access.
- There were no baby changing facilities in the practice and patients would be directed to a free consultation room to change their baby if one was available. The corridor to access clinical rooms was narrow but we were told that this was wheelchair accessible. However, there were no disabled toilets and the patient toilets did not appear to be accessible to those with mobility needs. The practice were aware of these issues and had obtained an improvement grant to upgrade the premises but was waiting for clarification about the future of the premises before instigating improvement work.
- The practice had facilities to deliver care and treatment but the premises were not appropriate for the services delivered. For example the practice provided enhanced services for violent patients. This service was previous held at another location. We were told that the practice now had to accommodate these patients on the premises. The reception area could be accessed easily by patients if desired. We asked staff about this and were told that none of the patients treated under this contract had attempted to access reception.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- Although we found deficiencies in the practice's safeguarding procedures we did see examples where children living in disadvantaged circumstances who were at risk were referred to social services.
- The practice could refer patients to the local primary care extended access service which was open between 8 am and 8 pm seven days per week.
- The practice hosted midwives at the practice every Tuesday.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The practice opened at 7.30am Monday to Friday and closed at 8 pm on Mondays and Tuesdays. Appointments were available late Monday and Tuesday and early on a Friday. However, the earliest nursing appointment was 10.30 am on a Friday. Although late appointments were available until 7.10 pm on Mondays and Tuesdays. Patients could be booked into the local extended primary care extended access centre which offered appointments from 8 am to 8 pm seven days a week.
- The practice provided fast track registrations to students from a local university.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours. The practice provided online appointments and prescribing and 45% of their patients were signed up to this service.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Eleven of the 21 patients on the practice's learning disability register had received a learning disability check. We were told by the practice nurse of a patient with learning disabilities who was unable to verbalise. As a result they had created flashcards to enable the patient to express how they were feeling during the consultation.
- The practice was signed up to an enhanced service for violent patients who had been removed from other practice registers. These patients were accommodated on a Tuesday afternoon.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had connections to a local charity which aimed to bring people together to tackle social isolation and improve the mental wellbeing of people living in the community.
- The practice referred patients to a local counselling service and hosted a private counsellor twice weekly.

Timely access to the service

Most of the patients we spoke with on day told us that they were able to access care and treatment from the practice within an acceptable timescale for their needs. However, national patient survey scores rated the practice lower than the national average in respect of access.

Feedback from patients indicated that:

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Delays and cancellations were minimal and managed appropriately. Though some patients said that waiting times could be in excess of 15 minutes.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

However, results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages. This contrasted with our observations on the day of inspection and the completed comment cards received. Three hundred and sixty surveys were sent out and 110 were returned. This represented about 2% of the practice population.

- 65% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 80%.
- 63% of patients who responded said they could get through easily to the practice by phone; CCG – 75%; national average - 71%.
- 56% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 73%; national average - 75%.
- 65% of patients who responded said their last appointment was convenient; CCG - 75%; national average - 81%.
- 46% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%.
- 34% of patients who responded said they don't normally have to wait too long to be seen; CCG - 51%; national average - 58%.

The practice provided us with information on action taken to try to improve patient satisfaction with access. The practice opened from 7.30 am every day and a new telephone system had been introduced increasing the number of lines and directing patients to call at different times for test results in an effort to ease congestion. They promoted alternative services including online access and pharmacy first. A new triaging appointment system and telephone consultations had been introduced to allow better use of face to face appointments and the practice had employed an additional GP on Monday and Tuesday mornings.

The practice had also introduced 10 minute 'catch up' slots for every three regular GP appointments and text reminders for appointments advising patients to book double appointments if they had more than one issue which needed to be discussed.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The system in place to handle complaints was not effective. There was not clear leadership and oversight in this area and the practice was unable to produce any responses given to complaints.

- Information about how to make a complaint or raise concerns was available on a notice board in the reception area and on the practice website, though take away copies needed to be requested from reception staff.
- The lead noted in the complaint policy was not the person accepted by most staff as the person responsible for complaints. Three complaints were received in the last year. We saw evidence of acknowledgement but staff could not provide us with any responses. The complaint lead told that the process was confused and did not operate effectively.

Are services well-led?

Inadequate

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

Our findings

The practice is rated as inadequate for providing services that were well led.

Leadership capacity and capability

Leadership in the practice was fragmented and did not operate effectively.

- Management responsibilities were split between various members of staff. Staff who led in key areas were not fully aware of their responsibilities or how things operated. Some staff were unaware of which staff member led in certain areas and feedback from staff contradicted documented information on leadership within practice policies.
- Issues around the premises had created uncertainty regarding the future viability of the practice and we were told that this was one of the reasons that the practice had delayed decisions related to future staffing including employing a new practice manager.
- The practice manager only attended the practice twice a month and most staff we spoke with did not know what role the practice manager performed.
- Some staff did not have capacity to takle on the full range of responsibilities due to having limited capacity as a result of the workload stemming from their areas of primary responsibility.

Vision and strategy

The practice had an overarching vision regarding the future direction of the practice but it was evident that the lack of effective leadership and governance impacted on the practice's ability to implement strategic goals, deliver high quality care and promote good outcomes for patients.

- There was a lack of clear vision. Although the practice aimed to become a partnership and make improvements to the premises, we were told that their ability to plan for the future had been hindered by uncertainty around the premises. The practice had produced a document in June 2017 which aimed to identify efficiencies. It was evident from reviewing the document that the practice was aware of the challenges they faced and areas where improvement was required. For example the report stated that no one was responsible for CQC policies and procedures. Several staff were noted as potentially taking on this responsibility including a new practice manager or the practice nurse. However, there was no clear plan in place to address the issues identified and there was no evidence of the plan having been subsequently reviewed.
- We saw evidence that patients had been consulted on changes within the practice including the appointment systems. The efficiency review indicated that a broad range of staff were involved in discussions around the future direction of the practice.

Culture

The practice encouraged staff to be open and honest but in some respect support was insufficient. For example, there was no documented evidence of internal appraisal, and a lack of managerial support meant that some staff were overburdened.

- Staff stated they felt respected and valued and most felt supported in their day to day working. However, some staff told us that managerial support was lacking. We were told by staff that the absence of a permanent practice manager working on site had put additional pressure on other staff members and there was a lack of clarity as to who was responsible for what.
- It was unclear how performance of staff would be managed.
- The provider was aware the duty of candour and gave an example which demonstrated compliance with the duty. However, the systems in place to ensure compliance were ineffective. We saw no responses to complaints and there was no formalised policy in place for the management of significant events.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- We were told by a member of staff employed via the federation, who provided support with IT and QOF, that all staff had received an appraisal within the last twelve months but they confirmed that there was no paper work as these had not been written up. Two members of staff we spoke with stated that their appraisal was due and were uncertain when their last appraisal had been. Staff were supported to meet the requirements of professional revalidation where necessary.

Are services well-led?

Inadequate

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

- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- Lack of effective oversight of risk, leadership and governance generally put staff at risk; particularly in respect of fire safety and infection control.
- There were positive relationships between staff and teams.

Governance arrangements

There was a lack of clarity around key areas of responsibility and accountability. Governance systems did not operate effectively. Policies lacked clarity, were not practice specific and contained inaccurate information.

- Structures, processes and systems did not support good governance and management was lacking in key areas including complaints, significant events and infection control. Staff were often unclear on their roles and in these areas.
- Policies were not tailored to the specific needs of the practice; for example, the practice's adult safeguarding policy was from another service. We were provided with a practice specific policy after the inspection but this did not detail the practice lead. Some policies were not present at all; for example, there was no fire safety policy. The governance framework was not effective. For example there was little evidence of risk management and the procedures for managing complaints was disorganised and confusing.

Managing risks, issues and performance

Systems to manage risks, issues and performance were absent or insufficient.

- There were few processes in place to identify, understand, monitor and address current and future risks including risks to patient safety. For example there was little in place to mitigate risks associated with fire and no evaluation of risks associated with infection control.
- The practice did not have processes to manage current and future performance. Consultations and referral decisions were not audited although we some examples of prescribing reviews. Practice leaders lacked oversight of MHRA alerts and complaints.
- Clinical audit had limited positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans in place for major incidents though some staff had not completed basic life support training within the last 12 months.

Appropriate and accurate information

The practice had access to appropriate and accurate information. However, there was no evidence of internal clinical meetings where the quality of patient care was reviewed and discussed and the practice had not taken action to address some areas of poor clinical performance.

- There was limited evidence that the practice used data to plan how to improve areas of weaker performance. For example, while the practice were able to provide reasons why they thought that uptake of cervical screening and immunisations was low there was no plan in place to improve patient engagement in these areas.
- We saw no evidence of quality being discussed at meetings. We were told that meetings were held every Monday. Staff said that notes had been taken for meetings but not written up. The last set of notes we could find from an internal practice meeting were from January 2016.
- The information used to monitor performance and the deliver care was accurate and useful.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice took into account feedback from patients and staff.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group. The practice hosted a dermatologist and invited patients to attend a presentation about skin health.
- The service was transparent, collaborative and open with stakeholders about performance including the local federation.

Are services well-led?

Inadequate

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

Continuous improvement and innovation

We saw some examples of innovative practice.

- The practice nurse had created a template for travel immunisations together with support from a colleague within the federation. This provided prompts to ensure that nursing staff asked and recorded all pertinent information before administering travel immunisations. This was supported by a travel pack that the nurse had produced. We also saw that the nurse had created a pack for pre diabetic patients with advice on diet and links to other sources of information.
- The practice nurse had introduced relaxation sessions which aimed to relax patients who had anxieties about invasive procedures stemming from previous trauma. This involved playing relaxing music, using breathing techniques and giving patients equipment that they could practice with so they knew what to expect when they attended for certain examinations or procedures.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** Systems and processes had not been established to prevent abuse of service users as the practice's safeguarding policies were not customised to the practice's needs and staff were not chaperoning in accordance with best practice. This was in breach of regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** There were not sufficient numbers of suitably qualified staff employed to ensure adequate nursing provision and managerial oversight. Not all staff had received the required essential training including safeguarding, information governance and basic life support training in accordance with current legislation and guidance. This was in breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Warning notice** **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. They had not assessed risks associated with fire, legionella, infection control, patient safety alerts, the management of medicines, emergency procedure, urgent referrals and recruitment. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Warning notice** **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. There was a lack of effective policies procedures and governance to enable effective management of risks associated with fire, legionella, infection control, patient safety alerts, the management of medicines, emergency procedure, urgent referrals and recruitment. There was a lack of effective systems in place to monitor staff training and appraisal and no action plan in place to address areas of clinical

This section is primarily information for the provider

Enforcement actions

performance which was below local national averages and there were no documented internal meetings from the last 12 months. The systems for managing complaints and significant events and. governance arrangements around chaperoning and safeguarding were not effective.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014