The Practice Hangleton Manor

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Practice Hangleton Manor on 8 September 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective and caring services and for being well led. It was also inadequate for providing services for all of the population groups. Improvements were also required for providing responsive services.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example the practice did not have a clear system in place for identifying children at risk. Risks to patients in relation to referral and appointment systems had not been adequately considered.
- Risks to patient's health were not always managed.
- Staff were clear about reporting incidents, near misses and concerns and there was evidence of investigation, however learning and communication with staff was not consistently apparent.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example QOF performance data was significantly lower for the practice than the clinical commissioning group (CCG) or national averages. Reviews of chronic disease management were undertaken in an opportunistic rather than planned way, and there were no comprehensive plans in place to address poor patient outcomes.
- There was no comprehensive system in place to recall and review patients.
- There were no multidisciplinary meetings held to discuss vulnerable patients. Palliative care meetings had begun to take place although the practice had not adequately identified patients who were nearing the end of life.

Summary of findings

- The practice did not have a clear system in place for sharing information with ambulance or Out-of-Hours services for patients with complex needs.
- The practice had a plan for nurse-led health promotion campaigns for the year and had demonstrated success in identifying people at risk of dementia and providing appropriate health checks for these patients.
- Nursing staff participated in meetings with other nurses working within The Practice group/Chilvers and McCrea Brighton based practices. We saw evidence that these meetings included discussions around service planning and training with an emphasis on better meeting the needs of patients.
- Patients we spoke with were positive about their interactions with staff and said they were treated with compassion and dignity. However there was evidence from other feedback sources that this was not consistently the case. It was unclear how the practice had responded to this feedback.
- Patient feedback about consultations with nursing staff were positive, with the practice scoring above average in terms of nursing staff giving patients enough time and involving them in decisions about their care.
- The practice did not undertake a patient survey and it was unclear how feedback from the Friends and Family test and national GP patient survey was used to improve services for patients. The practice was involved in a multi-site practice patient participation group but there was no evidence of how this influenced changes within the practice.
- Patient privacy and dignity was not sufficiently considered in relation to the environment.
- Urgent appointments were usually available on the day they were requested, however these were mostly telephone consultations. Patients said that they sometimes had to wait a long time to receive a call back from the GP and information for patients regarding the appointment system was unclear. Patients could not book non-urgent appointments without having had a telephone consultation with the GP first.
- There was a lack of leadership capacity within the practice to make the required changes to improve patient outcomes and experience.
- Systems used to monitor the quality of the practice were inconsistent and not being used effectively to improve the service.
- There were insufficient action plans to improve patient outcomes or satisfaction.
- The approach to performance, quality and risk was inconsistent.
- The practice had undertaken 79% of health checks for eligible patients aged 40 – 75.
- There were effective medicines management and infection control processes in place within the practice.

The areas where the provider must make improvements are:

- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure that safeguarding processes include a clear system for identifying children and adults at risk.
- Ensure that the practice referral system is adequately risk assessed and subject to regular quality review.
- Ensure that significant event analysis and complaints management is undertaken in a planned, formal process that involves all relevant staff and is subject to formal review.
- Ensure that risks to patient's health are appropriately managed and that there is a robust system in place for patient recall, review and care planning.
- Ensure there is a robust plan in place for improvements to patient outcomes, including clear prioritisation, action planning and review.
- Ensure multidisciplinary meetings are in place for discussions of the care of all patients who are vulnerable.
- Ensure patients who are nearing the end of life are identified and added to the palliative care register.
- Ensure that the practice clarifies the system for sharing information with the ambulance and out of hours service for patients with complex needs, ensuring that all relevant staff are aware of the system.
- Ensure that the practice appointment system is adequately risk assessed and subject to regular quality review.
- Ensure that patient feedback and input from the patient participation group is used to improve practice and develop the service.

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- Ensure that patient's privacy and dignity is maintained and that processes to ensure confidentiality are in place.
- Ensure that practice clarifies leadership structure and ensures there is leadership capacity to deliver all improvements.

The areas where the provider should make improvements are:

- Improve information available to patients on the website and in the waiting area about accessing appointments.
- Ensure all staff are up to date on their mandatory training.
- Ensure the practice has a process in place for providing support and follow up to patients who have been bereaved.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Patients were at risk of harm because systems and processes had weaknesses or were not in place to keep them safe. For example the practice did not have a clear system in place for identifying children at risk. Risks to patients relating to issues highlighted in the referral and appointment systems had not been adequately considered.

There was insufficient information to enable us to understand and be assured about safety because risks to patient's health were not always managed. For example, patients were not being recalled for reviews when risks had been identified. It was unclear how the practice was using learning from significant events and complaints to adequately improve services.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services as there are areas where improvements must be made. Data showed that patient outcomes were significantly below average for the locality and the practice did not have clear action plans on how these could be improved. QOF performance was at 59.6%, more than 30% below local and national averages. There was no clear framework for clinical audit cycles to take place. Multidisciplinary working was limited and the practice did not demonstrate joined up care for patients in a comprehensive formal way. Health promotion campaigns were being led by nursing staff, however there was not a comprehensive system in place for patient recall and patient reviews were not being undertaken proactively.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services and improvements must be made. Data showed that patients rated the practice lower than others for many aspects of care. Feedback from patients on how well they were treated was mixed and included examples of where they were not treated with respect and where staff lacked compassion and others where staff were kind and caring. Information for patients about the services was available but this was not kept up to date in relation to accessing appointments. The environment was not conducive to maintaining patient confidentiality, dignity and respect as conversations could be overheard in consultation rooms and in the waiting area.

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Are services responsive to people's needs?

Requires improvement 

The practice is rated as requires improvement for providing responsive services. The practice had an overview of the needs of their local population and was engaging with the clinical commissioning group (CCG) to secure improvements. The practice had sufficient facilities and was equipped to meet patient need. However, patient feedback, complaints and survey data showed that patients had experienced difficulties accessing appointments and had concerns about the practice system of telephone consultations. There was insufficient evidence that the practice had fully addressed these concerns or had fully considered the wishes and needs of patients when making decisions about the structure of the appointment system.

Are services well-led?

Inadequate 

The practice is rated as inadequate for being well-led. There was a clear leadership structure and staff felt supported by management; however it was unclear how staff within the leadership structure had capacity to deliver improvements. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. There was little evidence of how the practice planned to improve performance and issues that threaten the delivery of safe and effective care were not effectively managed. The practice had proactively sought feedback from staff and patients although there was insufficient evidence they had taken this feedback into consideration when making changes within the practice. The practice worked with a locality patient participation group (PPG), however it was unclear how the activity of this group impacted on or influenced the 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

Due to the issues identified within the practice the service is rated as inadequate for the care of older people. Nationally reported data such as the Quality and Outcomes Framework (QOF) showed the practice had outcomes significantly below average for conditions commonly found in older people. Older people of 75 or over had a named GP although only one patient over the age of 75 was seen to have a care plan in place. As part of CCG initiatives, the practice worked with a community navigator to arrange appointments with vulnerable patients to support them to access services and build relationships to reduce social isolation. The practice had begun to establish multidisciplinary meetings to discuss patients at the end of life. However they had not fully identified patients considered to be nearing the end of life. The practice had undertaken some activity to identify patients at risk of unplanned admission to hospital. However there were no care plans available relating to these patients.

People with long term conditions

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of people with long-term conditions. Longer appointments and home visits were available when patients needed them and patients had a named GP. As part of clinical commissioning group (CCG) initiatives, the practice worked with a community navigator to arranged appointments with vulnerable patients to support them to access services and build relationships to reduce social isolation. Personalised care plans and structured annual reviews were not undertaken in a planned comprehensive way to check that patients' health and care needs were being met. This meant that care plans and reviews for this population group were inconsistent. Nationally reported data such as the Quality and Outcomes Framework (QOF) showed the practice had outcomes significantly below average for many long-term conditions.

Families, children and young people

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of families, children and young people. There were unclear systems in place to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk. There was no evidence the practice participated in regular child protection meetings with external professionals such as health visitors although there was a

Summary of findings

child protection lead in post and staff were aware of the processes involved in raising concerns. The practice was unable to provide data on immunisation rates. The practice offered six week post-natal checks for mothers and babies.

Working age people (including those recently retired and students)

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of working-age people (including those recently retired and students).The age profile of patients at the practice was mainly those of working age, students and the recently retired and the practice had made some progress in developing services in a way that reflects the needs of these groups. The practice participated in a local extended hours service that offered appointments to patients in this population group outside of normal working hours. However, if patients wished to have an appointment with their regular GP they would have to do so via a telephone consultation process initially. This meant that patients would have to wait for a call from the GP and this would not necessarily be at a time that was convenient to them. Appointments could be booked online, however the information on the practice website about accessing appointments was out of date. The practice had worked to increase uptake for health checks for patients aged 40 – 75 and this had resulted in 79% of eligible patients attending and the practice continued to offer this service and encourage patients to attend.

People whose circumstances may make them vulnerable

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice did not have a system in place for ensuring patients living in vulnerable circumstances received an annual health check and there were no multi-disciplinary meetings held where care for these patients was discussed.

The practice had not worked with multi-disciplinary teams in the case management of vulnerable people. The practice did not have performance data available in relation to monitoring outcomes for patients with a learning disability, although they had patients on their learning disability register.

People experiencing poor mental health (including people with dementia)

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The practice had not worked with

multi-disciplinary teams in the case management of people experiencing poor mental health. However, they had worked to identify patients at risk of dementia and we saw that these patients had been offered a health check.

The practice had told patients experiencing poor mental health about support groups and voluntary organisations and we viewed information in the practice waiting area about these services. It did have a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health and we viewed an example of a prioritised assessment of a patient with poor mental health resulting in readmission to hospital.

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What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing below the local and national averages with the exception of patients finding it easy to get through to the practice by phone and nursing consultations. There were 117 responses and a response rate of 35%.

- 80% found it easy to get through to this surgery by phone compared with a clinical commissioning group (CCG) average of 76% and a national average of 73%.
- 82% found the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 79% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 85% said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 63% describe their experience of making an appointment as good compared with a CCG average of 76% and a national average of 73%.
- 57% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 66% and a national average of 65%.
- 49% feel they don't normally have to wait too long to be seen compared with a CCG average of 59% and a national average of 58%.

The practice provided us with details of feedback from the Friends and Family Test (FFT) which is a single question survey which asks patients whether they would recommend the practice to their friends and family. Of the eight responses the practice received, four stated they would recommend the practice. The other four responses were negative and included comments such as finding the queuing and call back system for appointments stressful and that surgery times did not cater for working people. As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received five comment cards. Four out of the five responses included comments about difficulties with the current appointment system. Issues identified included difficulties getting through on the phone, concerns about having to discuss health needs with reception staff before having to wait for a call from the GP, difficulties booking appointments in advance and difficulties getting face to face appointments on the day. Four of the responses included comments about the kind, helpful and caring nature of the staff within the practice.

We met with three patients on the day of inspection. Feedback from patients was mixed in relation to accessing appointments. All patients we spoke with told us they found the staff caring and approachable.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure that safeguarding processes include a clear system for identifying children and adults at risk.
- Ensure that the practice referral system is adequately risk assessed and subject to regular quality review.
- Ensure that significant event analysis and complaints management is undertaken in a planned, formal process that involves all relevant staff and is subject to formal review.
- Ensure that risks to patient's health are appropriately managed and that there is a robust system in place for patient recall, review and care planning.
- Ensure there is a robust plan in place for improvements to patient outcomes, including clear prioritisation, action planning and review.

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- Ensure multidisciplinary meetings are in place for discussions of the care of all patients who are vulnerable.
- Ensure patients who are nearing the end of life are identified and added to the palliative care register.
- Ensure that the practice clarifies the system for sharing information with the ambulance and out of hours service for patients with complex needs, ensuring that all relevant staff are aware of the system.
- Ensure that the practice appointment system is adequately risk assessed and subject to regular quality review.
- Ensure that patient feedback and input from the PPG is used to improve practice and develop the service.
- Ensure that patient's privacy and dignity is maintained and that processes to ensure confidentiality are in place.
- Ensure the practice clarifies the leadership structure and ensures there is leadership capacity to deliver all improvements.

Action the service SHOULD take to improve

- Improve information available to patients on the website and in the waiting area about accessing appointments. Ensure all staff are up to date on their mandatory training.
- Ensure the practice has a process in place for providing support and follow up to patients who have been bereaved

The Practice Hangleton Manor

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 practice manager specialist advisor.

Background to The Practice Hangleton Manor

The Practice Hangleton Manor offers general medical services to people living and working in the Hangleton area of Brighton and Hove. It is a practice with one female salaried GP providing eight sessions a week and one male locum GP providing two sessions a week. In addition a lead locality male GP for The Practice Group/Chilvers and McCrea Ltd was available for support the practice when needed. There are approximately 2000 registered patients.

The practice was run by The Practice Group/Chilvers and McCrea Ltd. The practice was supported by central management functions from the head office, including human resources, health and safety and clinical locality leads. The practice also had a practice nurse, healthcare assistant and a team of receptionists. Operational management was provided by the practice manager and assistant practice manager.

The practice runs a number of services for its patients including asthma clinics,child immunisation clinics, diabetes clinics, new patient checks, and weight management support.

Services are provided from:

The Practice Hangleton Manor, 96 Northease Drive, Hove, BN3 8LH

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a marginally higher number of patients over the age of 75 and under the age of 18, compared with the England average. The practice population also has a slightly higher number of patients compared to the national average with a long standing health condition and with health related problems in daily life. The practice population has low levels of unemployment and similar numbers in terms of working status or education, compared to the national average.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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

Detailed findings

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Brighton and Hove Clinical Commissioning Group (CCG). We carried out an announced visit on 8 September 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, and administration staff.

We observed staff and patients interaction and talked with three patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed five comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record

Safety was not a sufficient priority within the practice and there was inconsistent monitoring of safety. For example, we saw evidence of incidents being reported to the practice by patients and external agencies that had not been picked up on by the practice through the use of adequate safety systems. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example clinical staff we spoke with were aware of the online reporting procedures and cited examples of when this had been used.

We reviewed incident reports for the last year but saw limited minutes of meetings where incidents were discussed over the last six months. For example, safety and significant events was not a standard meeting agenda item and of the three sets of meeting minutes we viewed; only one included a discussion about specific incidents that had occurred.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of seven significant events that had occurred during the last year and saw this system was followed appropriately. Information from the system was collated and sent to head office for review. Staff within the practice told us that head office staff would involve them in discussions about reviews of individual cases but we did not see evidence of a report or review of past significant events being undertaken to identify trends or themes within the practice. Significant events was not a standing item on the practice meeting agenda and while staff told us that incidents would be discussed at meetings these were not always planned in advance so were not always consistent. There was no evidence of a dedicated meeting being held to review actions from past significant events and complaints. There was evidence that the practice had taken action to resolve incidents at the time they occurred and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us the system used to manage and monitor incidents. We tracked seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example we saw that three incidents relating to referrals not being processed in a timely way had resulted in a review of the referral system. Specific action included updating referral guidance given to locum GPs and ensuring clear processes were in place for both administrative staff and for GPs. However, it was not clear how the practice had learnt from these incidents in order to improve practice. For example all of the incidents relating to referrals had been raised with the practice by the patients involved. The incidents had led to significant delays in patients being seen by a specialist within the recommended NICE guidelines two week wait referral process for patients with a suspected cancer. We did not see evidence that the practice had considered how they would monitor changes to the way referrals were processed in order to identify that practice had improved, that the risk of delays had been mitigated and that errors would be identified in a timely way. Therefore, the practice could not be sure that an incident of this nature with referrals would not happen again.

National patient safety alerts were disseminated by the practice manager via email to practice staff and we viewed a folder of past alerts where clinical staff signed to say they had viewed it. We did not see evidence of alerts being discussed at meetings although staff told us this would be done on an informal basis amongst the clinical staff.

Reliable safety systems and processes including safeguarding

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and we viewed laminated flow charts in clinical and staff areas with clear instructions of how to escalate concerns and who to contact.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had

been trained in both adult and child safeguarding. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

The practice had a safeguarding children's register that was generated from information received from external agencies, however the practice did not have a clear internal system in place to identify, review or discuss children at risk with other relevant organisations including health visitors and the local authority. Therefore, the practice could not be sure that children at risk had been identified. There was a system to highlight vulnerable patients on the practice's electronic records which alerted staff to specific issues when they accessed the records. This included information to make staff aware of any relevant issues when patients attended appointments; for example we saw alerts on the patient record system where a patient with dementia was at risk of an acute admission. However, we did not see evidence of the practice having clinical meetings where vulnerable patients were reviewed or case managed. Therefore, the practice could not guarantee that they had a system in place to effectively monitor and safeguard vulnerable patients.

We viewed a recent incident where a local area safeguarding team had requested information from the practice relating to a safeguarding concern where the information was not provided in a timely manner. We viewed an incident report that identified a backlog of administrative work as being a key contributing factor in the delay. We saw that the incident had been discussed at a specific staff meeting called to review the issue and that action had been taken to address the issue. Action had included discussions with the local area safeguarding lead, information for administrative staff on appropriate coding of safeguarding tasks and GPs having dedicated time to respond to requests as appropriate. The practice had also identified the need for a clear protocol for locum GPs in dealing with safeguarding requests and we were told this was an area the practice was working on. It was unclear how the practice was monitoring safeguarding within the practice and there was no system identified to monitor that safeguarding concerns were addressed in a timely way.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medicines was stored at the appropriate temperature. We viewed records of an incident where the fridge temperature had gone outside of range and we saw that appropriate action had been taken. This included contacting the vaccination manufacturer for advice, identifying alternative storage arrangements and reporting the incident as a significant event.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We saw that an ongoing audit of high risk medicines was carried

out and that appropriate action was taken in relation to their management. One example of how this was managed was that patients' blood results would be checked prior to medicines being prescribed.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated within the last year. We saw evidence that nursing staff had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out infection control audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in February 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The process of recruitment was maintained by the central office functions of The Practice Group/Chilvers and McCrea Ltd and we saw systems in place to support this. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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).

There was some evidence that arrangements had been made for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff across the

locality practices within The Practice group/Chilvers and McCrea Ltd, to cover each other's annual leave. However, a number of roles within the practice included staff who had responsibilities for other practices within The Practice group/Chilvers and McCrea Ltd. For example, the practice manager was responsible for four of the group practices within Brighton and Hove. In addition, other staff who supported The Practice Hangleton Manor had operational commitments to other practices within the group, for example the lead locality GP and lead regional nurse. The lead locality GP was operationally responsible for their own practice for eight sessions a week and had two administrative sessions each week to support four of the other group practices in Brighton and Hove. While we saw evidence that locum staff were used within the practice operationally, it was unclear that the practice had the appropriate staffing resources in place to address the areas of risk identified within the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice in relation to the environment. These included regular checks of the building, the environment, medicines management, infection control, control of substances hazardous to health (COSHH), staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw an example of this in relation to infection control and we saw that the mitigating actions that had been put in place included staff training and replacing equipment. We saw some evidence of risk being discussed at practice meetings.

Staff we spoke with were able to tell us how they would respond to changing risks to patients including deteriorating health and well-being. However, we saw evidence that risks to patients' health were not always consistently managed. For example, we saw records of patients with diabetes that showed routine foot checks were not consistently being carried out. In addition we viewed the records of a patient with hypertension who had not been recalled for a check of their blood pressure when it had been identified as significantly elevated during an appointment three months before. Therefore, the practice could not be sure that risks to patients' of deteriorating health and well-being would be addressed.

We saw that 77% of GP consultations were carried out over the phone. This involved patients calling the surgery and being put on a list for the GP to call back. Staff told us that the GP prioritised the patients in terms of how quickly to call them back based on the initial information given. However, we saw from patient feedback that this resulted in some patients waiting for several hours before speaking to a clinician. We viewed three complaints relating to the appointment system, including one where the patient had not received a call back for eight hours. On the day of our inspection a patient who had concerns following treatment had not been called back for more than five hours. The practice had not adequately assessed the risk to patients of the high percentage of telephone consultations or the time patients spent waiting for a call back.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support, however the salaried GPs training was out of date by a few months at the time of our inspection. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked on a monthly basis. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions

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Are services safe?

recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills, the most recent drill in June 2015.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. Staff told us that best practice guidance, guidelines form the National Institute for Health and Care Excellence (NICE) and from local commissioners was routinely used and cascaded. However, we reviewed minutes of staff meetings and did not see evidence of new guidelines being discussed. There was no evidence of the implications of guidelines on practice performance being discussed.

Patients were treated by GPs and nurses who would assess the patient's current need and refer to appropriate secondary care. We saw some evidence of the day to day management of long term conditions and staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. For example, we saw that nursing staff used templates from the CCG for diabetic care plans and assessments. However, we saw that patient reviews and care planning was inconsistent. For example, only one patient over the age of 75 had a care plan in place and not all patients with diabetes had a foot examination and risk classification undertaken. In addition only 62% of patients with chronic obstructive pulmonary disease (COPD) had attended for a formal review; in addition only 72% of patients with hypertension and 75% of patients with asthma had been reviewed. We saw that patients were routinely referred to other services or hospital when required and patients we spoke with confirmed this. However, we saw evidence from significant event reports of incidents relating to referrals not being processed.

The practice did not hold dedicated clinical meetings although we saw that the GPs were supported by the lead locality GP for The Practice Group/Chilvers and McCrea Ltd and was available for support and advice. Regular monthly nurses meetings were held for all nurses working within the Brighton based The Practice Group/Chilvers and McCrea Ltd practices. The nurse from Hangleton Manor attended these meetings and was the lead nurse for the locality within the group. Minutes from these meetings demonstrated that nurses attending would discuss new best practice guidelines, for example, for the foot assessments of patients with diabetes. It was not clear how best practice guidelines were discussed across the multidisciplinary clinical team as there were no regular multidisciplinary clinical meetings held. However, we did see that the practice had recently begun to hold palliative care meetings within the practice.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. However, there was not a comprehensive system in place to ensure patients were reviewed regularly so that multidisciplinary care plans were documented in their records. Staff told us that problems with the patient recall system meant that patients were not always being reviewed. Therefore, staff could not guarantee that patients' needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

There was limited monitoring of the outcome of people's care and treatment and action to improve people's outcomes was not consistently taken. Staff across the practice had key roles in monitoring and improving outcomes for patients; however staff told us this had been affected by there not being a clear system of patient recall in place.

The practice had a system in place for completing clinical audits. Staff told us it was the responsibility of the GP to complete these. The GP showed us six clinical audits that had been undertaken in the last 12 months and we viewed action plans and lessons learnt identified as a result of the audit. We also viewed consultation audits for all clinical staff that had been undertaken by the lead GP via a review of the practice record system. However, not all clinical staff were aware of the consultation audits having been carried out so it was unclear how these were used to improve.

Of the six clinical audits we viewed we did not see evidence of re-audit being used to complete the audit cycle and evaluate the ongoing changes to practice. We also did not see evidence of clinical audit being discussed at practice meetings or involvement of other staff in planning audits.

Inadequate

Are services effective?

(for example, treatment is effective)

In addition there was no evidence that clinical audit was being used to monitor and improve practice that had been identified as poor in relation to incidents and significant events.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics for patients with a urinary tract infection (UTI) and for those on treatment for asthma. Following the audit, the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice achieved 59.6% of the total QOF target in 2014, which was significantly below the national average of 93.5%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was worse than the national average (22.8% points below).
- Performance for asthma related indicators was worse than the national average (48.4% points below).
- Performance for chronic obstructive pulmonary disease (COPD) indicators was worse than the national average (43.8% points below).
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average at 6.4% points above.
- Performance for mental health related and hypertension QOF indicators were better than the national average at 4.9% points above.
- The dementia diagnosis rate was 0.42 percentage points below the national average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we were told it was an area they were planning to address with the appointment of a dedicated administrator to the role. The practice had not developed specific action plans relating to improving QOF indicators. Therefore, the practice could not assure patients that there would be imminent improvements in this area. At the time of the inspection the QOF figures available were for 2013/14. However, in the time since the report was written the 2014/15 QOF figures have been published. The 2014/15 figures showed an improvement in total achievement at 74.6% against the national average of 93.5% and CCG average of 93.2%.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had begun to make use of the gold standards framework (GSF) for end of life care. It had a palliative care register and had planned regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of two meetings having been held in the practice at three monthly intervals with involvement from external professionals including specialist staff. The practice had one patient on their palliative care register and we did not see evidence of the GSF having been used to identify the percentage of patients nearing the end of life in their practice population. Therefore, the practice could not be sure they had identified all patients with palliative care needs within the practice.

We were told that the practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example those with a learning disability or dementia. However, structured annual reviews were not consistently undertaken for people who were vulnerable or those with long term conditions. Clinical staff told us there was not a structured recall system in place for patients and that this meant that annual reviews and care planning was carried out in a more opportunistic manner.

We viewed the records of nine patients who had been reviewed and saw some inconsistencies in terms of the quality of chronic disease management. For example, we saw that patients with diabetes had been reviewed but had

not received a foot examination and risk score. We also saw that a patient with hypertension and an out of range blood pressure was given a repeat prescription without a plan for recall to do a repeat check of their blood pressure.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. However, we noted that the GPs basic life support training was out of date by a few months. The GP was up to date with their yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse was undertaking a degree course and non-medical prescriber module.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, spirometry and smoking cessation. Those with extended roles e.g. seeing patient with long-term conditions such as asthma, COPD, diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

We saw that where poor performance had been identified there were systems in place to ensure that appropriate action had been taken.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out-of-Hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 1.1% compared to the national average of 1.4%. The practice had a process in place to follow up patients discharged from hospital. However, the practice did not undertake a regular audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice did not hold routine multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups or children on the at risk register. However, they had recently begun to hold meetings for patients with palliative care needs and we viewed the minutes of two meetings that had been held in the previous months.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP Out-of-Hours provider to enable patient data to be shared in a secure and timely manner. We were told that information was sent to the practice each day, summarising any patient contact with the Out-of-Hours service. However, the GP we spoke with was not aware of a system for sharing appropriate information for patients with complex needs with the ambulance and Out-of-Hours services. Therefore, there was a risk that patients with complex needs would be adversely affected should their condition require input from the Out-of-Hours service.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those

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Are services effective?

(for example, treatment is effective)

from hospital, to be saved in the system for future reference. We did not see evidence that audits had been carried out to assess the completeness of these records or identify shortcomings.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they would implement it, although could not give us examples of patients it would refer to at the present time. All staff knew that patients should be supported to make their own decisions. We viewed evidence of DNACPR (do not attempt cardiopulmonary resuscitation) discussions with patients and saw that their choices and preferences were recorded and used to inform discussions.

Patients with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing and we saw one example of this. We did not see an example of a care plan for a patient with a learning disability. Nursing staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

The practice was registered to carry out minor surgery although this practice was not being undertaken.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the nursing staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 79% of patients in this age group took up the offer of the health check. Staff told us that a patient would generally be followed up within a week if they had risk factors for disease identified at the health check and that further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 82% of patients over the age of 16 and recently arranged for nursing staff to attend smoking cessation training so that they may proactively offer nurse-led smoking cessation clinics to these patients.

The practice had worked proactively to identify patients at risk of dementia and that a recent health promotion campaign had led to 100 patients being offered a health check. Staff told us this had led to five patients receiving a dementia diagnosis.

The practice's performance for the cervical screening programme was 71% in terms of the percentage of patients receiving the intervention, which was below the national average of 77%. We saw that exception reporting for cervical screening was high within the practice, 6.2% above the CCG average and 9.5% above the national average. Exception reporting applies where achievement is determined by the percentage of patients receiving the intervention but where patients do not attend for review after having been invited at least three times. Clinical staff told us they were not aware of the process of follow up for patients who did not attend for their cervical screening test and that they did not undertake telephone follow up for patients not attending.

We saw evidence that the nursing staff carried out regular health promotion campaigns and we saw a schedule of these that were planned in advance. The campaigns included raising awareness of vaccinations to identified patient groups who were considered to be at risk.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 44%, and at risk groups 67%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos were at 95% and five year olds at 90%. These were comparable to CCG/National averages.

Inadequate

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 national patient survey July 2015 and from the Friends and Family Test survey. The practice did not undertake their own patient survey and there was not an active patient participation group (PPG) in place (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patient satisfaction with how they were treated fell below both the CCG and national averages in relation to GP consultations. For example:

- 73% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 73% said the GP gave them enough time compared to the CCG average of 84% and national average of 87%.
- 78% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%

However, satisfaction scores on consultations with nurses was similar or marginally higher when compared to the CCG and national averages. For example:

- 91% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 92% and the national average of 92%.
- 95% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 92% and the national average of 92%.
- 100% had confidence and trust in the last nurse they saw or spoke to compared to the CCG average or 98% and the national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards and while the majority were positive about the service experienced in relation to the approach of the staff, four out of five had concerns about the appointment system within the practice. Patients said they felt the practice staff were kind, helpful and caring. They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

The practice switchboard was not located away from the reception desk and there was no shield across the reception desk to keep patient information private therefore telephone conversations held by reception staff could be heard by patients sitting in the waiting area. Staff we spoke with were aware of the need for confidentiality and all had signed a confidentiality agreement, however there was no evidence that staff had attended confidentiality or information governance training. 82% of patients said they found the receptionists at the practice helpful which was below average compared to the CCG (89%) and national averages (87%). We saw an example of a significant event that had occurred where test results had been given to a relative of a patient where it transpired it was the wrong patient. This was a confidentiality breach. While we saw that this issue had been identified and addressed at the time we did not see evidence of the incident being fully explored or it influencing staff training or changes to practice.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 significantly below average in these areas in terms of GP consultations. For example:

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Are services caring?

- 65% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 59% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%.

However, consultations with nursing staff were reported more positively, for example:

- 89% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 90% and the national average of 90%.
- 88% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

We spoke with a small number of patients on the day of our inspection and they mostly told us that health issues were discussed and they didn't have any complaints with their consultations. However, we saw limited evidence of up to date care planning and patient involvement in that.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice nursing staff and rated it well in this area, however feedback was more negative regarding emotional support provided by GPs. For example:

- 64% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

Notices in the patient waiting room and on the patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff were not aware of arrangements in place within the practice if families had suffered a bereavement, however clinical staff were aware of local support groups that were available to help people who had been bereaved.

The practice participated in a local proactive care initiative and hosted a community navigator at the practice one day a week. The role of the community navigator was to support patients who were vulnerable or at risk of isolation to access services and support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to respond to patient's needs and had systems in place to maintain the level of service provided. The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. For example, the practice had engaged in a CCG proactive care initiative, working with other practices within the locality to improve outcomes for people in vulnerable circumstances in order to improve their access to primary care. This project was in the early stages of planning and involved the practice working with other surgeries within locality 'clusters'. The practice had systems in place to maintain the level of service provided which involved working together with other practices within The Practice Group/Chilvers and McCrea Ltd. The needs of the practice population were understood and we saw some systems in place to address identified needs in the way services were delivered.

The practice also participated in a multi surgery patient participation group (PPG). The group met regularly to discuss issues relating to each of the surgeries involved. We were told that the group enabled communication with patients and allowed for information to be shared about local services. However, the practice could not demonstrate how this group actively participated in the development of services to meet people's needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, we were told that longer appointment times were available for patients with learning disabilities or those with communication difficulties. The majority of the practice population were English speaking patients but access to online, telephone and face to face translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. They also worked closely with a partner The Practice Group/Chilvers and McCrea Ltd practice that specialised in healthcare for the homeless population. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice. Therefore patients could choose to see a male or female doctor.

Access to the service

The practice offered online booking for appointments and ordering of repeat prescriptions, although patient uptake had so far been low. The surgery was open from 8am to 6pm Monday to Friday. Between 6pm and 6.30pm calls to the surgery were diverted to a mobile phone held by the GP. Appointments were available from 8am to 6pm on weekdays. However, the majority of appointments available were telephone appointments with pre-bookable appointments only available via the GP. Same day appointments were available but patients would have to have a telephone consultation with the GP before they were booked into one of these appointments. Patient feedback about this process was poor, with patients we spoke to during the inspection telling us that they would have to wait for the GP to call them back, sometimes for several hours. We also received feedback to this effect via the CQC comment cards and in the practice feedback from the Friends and Family Test, including patients reporting that advance booking for non-urgent appointments was difficult.

The practice fell below CCG and national averages (GP national patient survey) for patients being able to get appointments when they tried, the appointments being convenient, their experience of making an appointment being good and the time they had to wait to be seen. Practice staff told us that initially the system for telephone consultation had not allowed for any pre-bookable appointments but that up to four pre-bookable

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

appointments had been added in response to patient feedback. A GP we spoke to told us that in a typical day they would conduct 30 telephone consultations, four pre-booked face to face consultations and five same day face to face consultations. Therefore, 77% of consultations were telephone consultations. Staff we spoke with told us that the system allowed for a greater number of appointments in a day and that the GPs liked the system. There was no clear plan for how the practice would act to improve the patient experience of the current appointment system.

The practice participated in an extended hours project within the locality. This service enabled the practice to book patients in to see a GP at another practice for evening and weekend appointments although this would not be with a named GP.

Comprehensive information was not available to patients about appointments on the practice website. There was no mention of face to face appointments only being available after a telephone consultation with the GP, or that patients may have to wait for the GP to call them back. There was also no mention on the website of the availability of extended hours appointments. Information on the website stated that a nurse triage system was in place for urgent appointments but this was not the case. In addition, we were told that patients who accessed appointments via the website could book their appointments directly without being triaged by the GP, therefore patients with online access may be able to access appointments more easily than those without. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. The practice did not provide support to local care homes.

The patient survey information we reviewed showed patients responded negatively to questions about access to appointments and rated the practice below CCG and national averages in these areas. For example:

- 57% were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 63% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%.
- 57% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%.
- 80% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

Patients we spoke with were frustrated with the appointments system and said it was difficult to use and this experience was evident from our review of comment cards and other feedback mechanisms available to the practice. Patients confirmed that they could speak to a doctor on the same day if they felt their need was urgent although they would have to wait for a call back. Routine appointments were not available for booking in advance. The practice understood the needs of working people to the point that they had collaborated to ensure extended hours appointments were available through joint working with other practices. However, the practice had not considered the difficulties experienced by the working population in having to wait for a GP call back during working hours.

Listening and learning from concerns and complaints

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

We looked at a summary of complaints made during the previous 12 months. These included a summary of the nature of the complaint, action taken and learning points. We could see that the complaints had been investigated and that patients received a timely response and where necessary an apology. However, there was no evidence of an annual review having been carried out to explore themes and trends. We also saw that while action was taken on each individual complaint there was no evidence of how changes to practice were made to reduce the likelihood of further complaints. For example, we saw a complaint where a patient was unhappy that they were unable to advance book appointments. The patient had

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

been unaware of the availability of extended hours appointments yet the practice had not taken action to make this information more widely available on the practice website or in the practice waiting area.

We saw that information was available to help patients understand the complaints system was in place with information displayed in the patient waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last 12 months and found that these were generally dealt with in a timely manner. However, it was not always clear that opportunities to learn were taken from these complaints or that action had extended beyond the immediacy of the complaint to looking at opportunities to improve practice overall. There was a sense of openness and transparency in dealing with complaints and we saw that relevant staff were involved in investigations.

There was no evidence that the practice reviewed complaints annually to detect themes or trends or that ongoing improvements were made to the quality of care as a result of the way in which complaints were managed.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice's aims and objectives and the practice ethos was evident in their statement of purpose and this included treating patients with respect and involving them in their treatment and care. Specific aims included good education for staff, promoting healthy lifestyles for patients and ensuring strong governance systems within the practice.

While management staff were able to tell us of plans for the immediate future and staff had a number of ideas of how they wanted to develop the services, it was unclear how this was being planned for in a clear, robust and comprehensive way. We did not see evidence of a strategy or clear business plan. The practice vision and values included to involve patients in their care, to treat people with respect and offer high a quality service.

We spoke with six members of staff and they all knew and understood the vision and values, however it was not clear what the long term strategy of the practice was. Staff were aware of the areas the practice had prioritised but were not consistently clear about their role in addressing this. For example, all staff we spoke with were aware that it was a practice priority to improve their QOF performance yet staff were not always sure of their role within this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The policies and procedures we looked at had been reviewed annually and were up to date and staff had signed to confirm that they had read the policy and when.

There was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. In addition, there was governance support from the central office of The Practice Group/Chilvers and McCrea Ltd. We spoke with six members of staff and they were generally clear about their own roles and responsibilities. However, the governance role of the central function of the group was unclear. We saw that the practice fed information back to the centre and that there was involvement from staff with central roles in the management of significant events and complaints. However, it was unclear how issues were processed in terms of identifying trends, themes, learning and action to improve the service overall and it was unclear where the responsibility for this lay.

The lead locality GP and practice manager for The Practice group/Chilvers and McCrea Ltd took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. However, the practice manager had responsibility for four of The Practice group/Chilvers and McCrea Ltd practices within the locality and the lead GP was based in another practice for eight sessions a week with an additional two sessions of administrative time to provide support to four practices within the group.

Systems in place to monitor the quality of the service were not being consistently used and were not effective. For example the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures) showed that the practice was performing significantly below national standards. As much as 40% below average in many areas. While we were told that QOF data was regularly discussed at monthly meetings we saw limited evidence of this and there were no action plans produced to maintain or improve outcomes.

While the practice had made use of clinical audits there was not a structured programme in place that demonstrated the use of audit to monitor quality and systems to identify where action should be taken. For example we saw evidence of prescribing incentive audits and consultation audits having been carried out but these were not full cycle audits used to demonstrate improvements. In addition, there were a number of areas within the practice where incidents had occurred or where there was poor patient satisfaction e.g. referrals and access to appointments where the practice had not proactively sought to examine the systems using the audit tools available to them. Evidence from other data sources, including incidents and complaints was not used to identify areas where improvements could be made. Additionally, the processes in place to review patient satisfaction was not robust in terms of taking action to improve patient experience.

Are services well-led?

Inadequate

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

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example in relation to health and safety, fire safety and COSHH (control of substances hazardous to health).

The practice did not hold regular staff meetings where governance issues were discussed. These were held on more of an ad hoc basis and staff told us they were not always regular. Minutes from these meetings were limited and we found that the approach to discussing performance, quality and risks was inconsistent. Management staff told us they met regularly with the group leads to discuss issues within the practice, however we did not see minutes of these meetings.

We reviewed a number of policies, for example disciplinary procedures, induction and employment policies which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff.

Leadership, openness and transparency

The lead staff within in the practice were visible and staff told us that they were approachable and always take the time to listen to all members of staff. Staff told us they were involved in discussions about how to run the practice and how to develop the practice, and that they had the opportunity to raise any issues and felt confident in doing so and supported if they did. However, we found from meetings minutes and staff feedback that team meetings were held inconsistently.

We viewed three sets of meeting minutes and did not see a standard agenda format being used. One had an agenda that included items such as named GPs, QOF and test results, whereas another 'ad hoc' meeting was in response to specific significant events and complaints. There was no evidence that significant events and complaints were structured agenda items for discussion at each meeting.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through complaints received and comments relating to the Friends and Family Test (FFT). The practice did not carry out their own internal patient satisfaction survey. The practice participated in a multi surgery PPG (patient participation group). The group met regularly to discuss issues relating to each of the surgeries involved. We were told that the group enabled communication with patients and allowed for information to be shared about local services. However, the practice could not demonstrate how this group actively participated in the development of services to meet people's needs and the PPG had not been involved in collating or analysing patient feedback to improve services.

We did not see evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice performed below national and CCG average in all areas of the survey with the exception of patients finding it easy to get through to the surgery by phone and consultation with nurses. There was little evidence of the practice actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice and told us they worked well together as a team and would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had regular training with guest trainers and speakers.

We saw evidence that the practice had recorded seven significant events in the past 12 months. We saw evidence of action having been taken and that three incidents had been discussed with staff in an 'ad hoc' meeting that had been called as a result of the incidents. However, we did not see evidence of the practice having completed comprehensive reviews of significant events and other incidents and it was unclear how the practice monitored their systems and processes in order to identify when things went wrong. For example we saw evidence of five significant events that had direct impact on patient care. These included three incidents that had resulted in delayed referrals, one incident that resulted in a delay in information being shared relating to a safeguarding issue

Are services well-led?

Inadequate

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

and another incident relating to a breach in confidentiality. In all cases the incidents had been brought to the attention of the practice by external agencies or by patients. While the practice had taken some action to address each individual incident there was no evidence that they had taken action to review or monitor the systems in place using tools such as audit or risk assessments. Therefore, the practice could not be sure that the risk of similar incidents occurring in the future was sufficiently mitigated or that the system itself was adequately robust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **We found that the registered provider had not ensured the privacy of the service user.** **This was in breach of regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **We found that the registered provider had not ensured systems and processes were established and operated effectively to prevent abuse of service users.** **This was in breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that the registered provider had failed to provide treatment in a safe way and had not ensured that patients were protected from risks associated with receiving care or treatment.** **Had failed to ensure risks had been assessed and taken reasonably practicable steps to mitigate any such risks.**

This section is primarily information for the provider

Requirement notices

Had failed to ensure appropriate arrangements were in place to share relevant information promptly and in line with current legislation and guidance with other agencies involved in the care and treatment of patients.

This was in breach of regulation 12 1, 2(a)(b)(I)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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider had not always assessed, monitored and mitigated the risks relating to the health safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. We found that the registered provider had not always assessed, monitored and improved the quality and safety of services provided. We found that the registered provider had not always taken action to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. We found that the registered provider had not always evaluated and improved their practice in respect of mitigating risk, improving the quality and seeking and acting on feedback on the services provided. This was a breach of regulation 17 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014