Ashwood Surgery Limited

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ashwood Surgery limited on the 21January 2015. As part of this inspection we made a further two unannounced visits to Ashwood Surgery on 9 and 10 March 2015. We gathered information from a variety of sources, spoke with patients, interviewed staff at all levels and checked the right systems and processes were in place.

Concerns regarding this practice from different sources had been raised with us in relation to access to appointments, lack of continuity of care, poor support of locum GPs and that often there was not a GP available to patients. We were told that there was instances when the lead GP was only available in the practice for a short period each day.

Specifically, we rated the practice inadequate for the service being well led, safe, responsive and effective it was rated as requires improvement in caring. It was also inadequate for providing services for the six population groups we reviewed.

We gave the practice an overall rating of 'inadequate'.

- The practice had previously been inspected in June 2014. During which, we found concerns in relation to care and welfare of patients, safeguarding patients, cleanliness and infection control, management of medicines, requirements relating to workers, supporting workers and the management of records. There were also ongoing financial disputes regarding the payment of bills which resulted in a disruption to service provision. Concerns were also raised around lack or staff support and failure to pay some staff pension contributions. We saw that the practice had made some progress to address these concerns. However, we still found concerns at this inspection relating to assessing and monitoring the quality of service, governance arrangements, ineffective management of risks and monitoring of performance.
- The practice had reviewed and updated the staff handbook and a number of policies and procedures.
- Patients were at risk of harm because systems and processes were not sufficiently robust to keep them

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safe. For example the practice did not record all significant events in sufficient detail and therefore were unable to learn from these events and prevent reoccurrence.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Some safety information was recorded but action and learning from these was not always evident.
- Patients were positive about their interactions with staff and said they were treated with respect and dignity.
- Patients said they found it difficult to make an appointment which included same day urgent appointments. Patients also complained that sometimes there was no GP in the practice. The routine appointment system was not working, and patients were often waiting a long time for non-urgent appointments with the GP of their choice.
- Patients were unhappy about the frequent turnover of staff which led to the lack of clinical continuity of care.
- Lessons learned from significant events were not shared with staff so improvements could be made.
- There was little evidence that national best practice guidelines were being followed.
- We saw instances where patients received care from staff who had not completed appropriate training to deliver it.
- Patients experienced difficulties in accessing urgent appointments.
- The routine appointment system was not working, and patients were often waiting a long time for non-urgent appointments with the GP of their choice.
- There was no evidence of completed audit cycles beyond one audit cycle.
- There was a lack of continuity of care due to the changes in clinical staff. The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider needs to make improvements are;

Importantly, the provider must:

- Ensure there is a system in place for clinicians to be kept up to date with national guidance and guidelines.
- Ensure the practice monitor and review significant events.
- Ensure the practice have systems in place to review the effectiveness of learning from incidents.
- Ensure there are systems for assessing and monitoring risks and the quality of the service provision.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure there are formal governance arrangements to improve patient care. All staff need to be aware of the importance of governance to improve patient care.
- Ensure a sufficient number of clinical staff are employed to safeguard the health, safety and welfare of patients.
- Ensure that patient records contain a rationale for the treatment prescribed and document sufficient information which would enable another clinician to effectively take over care for a patient.
- Ensure appropriate support and training is in place for the practice nurse and health care assistant.

In addition the provider should :

- Ensure the practice website provides up to date information to support patients.
- Ensure there is information to signpost patients to support services or advise on what action to take in an emergency.
- Ensure all staff are familiar and aware of the business continuity plan.
- Ensure there are systems so a locum GPs can access clinical peer support in the surgery.
- Ensure processes are in place to prevent accidental turn off of the vaccination storage fridge which is not hard wired.

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. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, records, reviews and investigations were not thorough enough. Lessons learned were not communicated widely enough to support improvement. Records were not available regarding the significant events we were told about. There was no evidence to show significant events were regularly discussed.

Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe. Although risks to patients who used services were assessed and a risk register was in place, there were no clear records of when the actions were completed or by whom. The impact of the risk on patients was not identified. We were told the practice used the datex system to record incidents and risks. However the practice manager was not able to show us a record of these entries into the system nor the actions planned following identification of incidents.

At our last inspection in June 2014 the practice was non-compliant in several areas. Following this inspection we asked them to make improvement in the management of infection control, safeguarding, recruitment, medicines management and dealing with emergencies. We saw the practice had followed the action plan they had submitted to the Commission to address these required improvements.

There was insufficient information available to us, to enable us to understand and be assured about patient safety. We reviewed 20 patients' medical records and found four instances where care was not in line with published research and guidance. We saw instances where patients received care from staff who had not completed appropriate training to deliver it.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. Knowledge of and reference to National Guidelines aimed at delivering good patient care was inconsistent. Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. Patient outcomes were hard to identify as little reference was made to audits. There was no evidence to show the practice

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was comparing its performance to others, either locally or nationally. We saw one audit which had completed only one cycle. We were unable to judge the impact on patients from this one cycle. Multidisciplinary working was taking place.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there were areas where improvements should be made. Data from the national patient survey showed that patients rated the practice lower than others for some aspects of care. The majority of CQC patient comment cards and patients spoken with on the day of the inspection showed patients

were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.

There were limited health education/leaflets available in the practice waiting area. The information on the practice web site was not up to date.

The majority of patients we spoke with were complimentary about the staff. However some patients we spoke with and those who completed CQC comment cards told us accessing services was difficult. They also found the continual changes in clinical staffing difficult because they did not have continuity of care.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services and improvements must be made. There was no evidence that the practice had reviewed the needs of its local population or had a plan to identify any improvements that may be required. Feedback from patients reported that access to a named GP and continuity of care was not always available. We received comments that patients experienced difficulties accessing same day appointments and accessing appointments with the GP of their choice. The practice had good facilities and was equipped to treat patients and meet their needs. However there were limited clinical personnel available to meet the needs of the practice population. Patients could get information about how to complain and they were responded to appropriately. There was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. The practice did not have sufficiently robust governance arrangements to protect patients and ensure risks to patients were appropriately managed. The practice had a vision and strategy although staff we spoke with

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were unaware of this. Practice meetings were held but these were not regular and there was not documented evidence to demonstrate performance and risk were routinely discussed to ensure effective governance and oversight.

The practice had a number of policies and procedures to govern activity. The practice had a patient participation group (PPG). The frequency of the PPG meetings was unclear and seemed to be driven by the practice staff. It was unclear if suggestions made by the PPG were listened to or acted upon.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

The provider was rated as inadequate for safe, responsive, effective and well led . The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered personalised care to meet the needs of the older people and had a range of enhanced services, for example, in dementia and end of life care. The number of older people in the practice was below the national average. As this was a single handed GP practice all patients over the age of 75 years had a named GP. Patients over the age of 75 years identified as needing extra support and had been offered a review at the practice. The medication reviews were undertaken by the GP. The staff we spoke with were proactive in screening for dementia and referring patients for ongoing care and treatment. We did not see evidence that older people were offered rapid access to appointments. Income deprivation affecting older people in this practice was 29% which is above the national average. This suggested this group of patients would require extra support to stay healthy.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe, responsive, effective and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were processes in place and referrals were made for patients whose health deteriorated suddenly. We saw the practice nurse undertook reviews of patients with long term conditions. Longer appointments were available when needed. It was unclear if home visits could be requested for reviews to be undertaken at home. As this is a single handed practice these patients had a named GP. However the practice had for long periods of time operated with only one GP and no nurse; this made it difficult to provide on-going care.

We saw the practice nurse had received appropriate training in the management of long term conditions. The practice provided limited access to information for patients with long term conditions. Information regarding long term conditions was not available on the practice website and there was limited information available in the waiting area to assist patients to self-manage their conditions. The clinical staff had information available in the consulting rooms that

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could be given to patients at their appointments. We saw 48.6% of the practice population were suffering from a long term condition. We saw from the patient's records that national guidance in the management of long term conditions was not always being followed.

Families, children and young people

Inadequate

The provider was rated as inadequate for safe, responsive, effective and well led . The concerns which led to these ratings apply to everyone using the practice, including this population group.

Patients had access to a weekly immunisation clinic held by the practice nurse. A full range of immunisations, were offered although data supporting the extent of performance in this area was not made available to us. Midwifery services were held outside of the practice by the community midwives.

We were told there were no formal arrangements were in place for children to access appointments outside of school hours. However staff told us that they would always try and accommodate children. We received several comments from parents who were unhappy with access to same day appointments for their children. We saw on two occasions the practice nurse had reviewed a child and an adolescent offering advice. The health care professional had not been provided with the appropriate clinical training and skills to undertake this role. We saw national guidance and good practice had not always been followed.

The number of patients in the practice under the age of 18 years was well above the national average. Income deprivation affecting children was 31%, well above the national average. However we saw no services to improve access for young children, babies or young people. The problems that may arise from this high number of children in an area of high deprivation were not addressed. We were unable to establish what systems were in place within the practice for identifying and following up children living in disadvantaged circumstances and who may be at risk. For example, children and young people who had a high number of A&E attendances.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, responsive, effective and well led . The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice offered two days opening from 08.00hrs until 19.30hrs and 08.00hrs to 18.30hrs on the other three days. We saw that appointments during the extended hour's period on a Thursday

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were available only with the practice nurse for routine appointments. The locum GP and the practice nurse provided extended cover on a Monday. The single handed GP was available via the telephone for any advice or emergencies on the Thursday. Patients were unable to access online appointments via the website. The practice had planned to develop further access to online appointments and increase the number of patients requesting repeat prescriptions via this route.

We saw health promotion advice was offered but there was limited accessible health promotion material available in the practice. There was no access to up to date information on the practice website. The practice population for those working or in fulltime employment was 55% which is below the national average and 16% were unemployed which is higher than the national average.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe, responsive, effective and well led . The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There were 40 patients with learning disability registered with the practice. The practice carried out annual health checks for people with a learning disability. At our inspection In January 2015 nine of the 40 patients registered with the practice had accepted the offer of and received an annual health check. The practice offered longer appointments for people with a learning disability. Whilst the practice held a register of patients with a learning disability there was no information about other people who may be vulnerable; such as homeless people or travellers. Systems were in place to raise safeguarding concerns with the local authority safeguarding team and staff had good knowledge of the process.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as Inadequate for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 96% of the total group. The practice referred patients to appropriate support services for those people experiencing poor mental health. We saw evidence the practice worked with local mental health support services situated in the building. Clinical staff were aware of how to care for people with mental health needs and

dementia and referred appropriately. We did not see systems in place to follow up on patients who had attended accident and emergency when they had been experiencing poor mental health. We were told there were twenty patients on the dementia register and that the practice was using the dementia toolkit. The dementia toolkit had been launched by NHS England to help GPs make a timely diagnosis and provide appropriate support.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Action the provider MUST take to improve:

- Ensure there is a system in place for clinicians to be kept up to date with national guidance and guidelines.
- Ensure the practice monitor and review significant events.
- Ensure the practice have systems in place to review the effectiveness of learning from incidents.
- Ensure there are systems for assessing and monitoring risks and the quality of the service provision.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure there are formal governance arrangements in place and staff are aware of how to implement these to ensure the practice functions in a safe and effective manner.
- Ensure a sufficient number of clinical staff are employed to safeguard the health, safety and welfare of patients.
- Ensure that patient records contain a rationale for the treatment prescribed and document sufficient information which would enable another clinician to effectively take over care for a patient.
- Ensure appropriate support and training is in place for the practice nurse and health care assistant.

Action the service SHOULD take to improve

- Ensure the practice website provides up to date information to support patients.
- Ensure there is information to signpost patients to support services or advise on what action to take in an emergency.
- Ensure all staff are familiar and aware of the business continuity plan.
- Ensure there are systems in place so a locum GPs can access clinical peer support in the surgery.
- Ensure processes are in place to prevent accidental turn off of the vaccination storage fridge which is not hard wired.

Ashwood Surgery Limited

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included three GPs, a practice manager and a CQC inspection manager.

Background to Ashwood Surgery Limited

Ashwood Surgery Limited is situated in the Weelsby View Health Centre, Ladysmith Road, Grimsby, and South Humberside. The registered patient list size of the practice is 4500. There is one full time female GP and one male locum GP, one full time practice nurse, one full time HCA, a practice manager, a part time secretary and seven part time reception / administration staff. The locum provision in the practice is via a temporary contract.

The practice has personal l medical services (PMS) contract with NHS England to provide essential services to patients who are ill and includes chronic disease management and end of life care.

Patients can book appointments face to face, and by the telephone. The practice treats patients of all ages and provides a range of medical services. The practice has opted out of providing out-of-hours services to their own patients. Patients use the 111 service when the practice is closed.

We undertook a scheduled comprehensive inspection on 21January 2015. During this inspection process we received concerns from people regarding access to care, and the overall management of the service. Because of this and as part of the inspection we also visited the practice unannounced on the evening of 9 March 2015 and during the day on the 10 March 2015.

The practice had previously been inspected in June 2014. This was a responsive inspection to concerns we had received. At the June 2014 inspection we found concerns in relation to care and welfare of people who use services, safeguarding patients, cleanliness and infection control, management of medicines, requirements relating to workers, supporting workers and the management of records. At this inspection we saw that the practice had made some progress to address these concerns.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We had previously inspected the practice on 13 June 2014 and found the practice to be non-compliant in several areas. The practice sent us an action plan telling us how and by when they would become compliant. We could see at the inspection on 21January 2015 that there had been improvements in addressing the identified non-compliance.

Detailed findings

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

How we carried out this inspection

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)

Before visiting Ashwood Surgery Limited, we reviewed information we held about the service and asked other organisations to share with us, what they knew about the service. We asked the practice to provide a range of policies and procedures and other relevant information before the inspection.

We carried out an announced inspection visit on 21 January and a further unannounced visit on the 9 and10 March 2015. During our inspection we spoke with a range of staff including the GP, practice nurse, HCA, practice manager and administration staff. We also spoke to two different locum GPs who were working at the practice in January and March 2015. We spoke with seven patients who used the service. We were able to speak with four members of the PPG following our inspection. We observed how patients were being cared for and talked with carers and/or family members. We reviewed 11 CQC comment cards where patients shared their views and experiences about the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice could not evidence they held regular meetings with staff to discuss issues such as significant events, safeguarding and complaints. There was no evidence available to show that significant events were analysed or that learning actions had been identified or reviewed. We found the record of one staff meeting which was held in January 2015 the week before our first announced visit. The practice manager told us there had been only this one staff meeting since our last inspection in June 2014. Risks to some patients who used the service had been identified and assessed but there were no dates of when this was done or when actions were completed.

The practice manager told us they use the datex system to report incidents. Datex is an incident and adverse events reporting system. However the practice manager was unable to provide or retrieve any information inputted by the practice. It was difficult to establish how the practice learnt from, share with staff and prevented further incidents occurring when they were unable to retrieve information.

A risk assessment policy was in place and had been reviewed in January 2015. We saw that some risk assessments had been undertaken. An example of this was lone working, when staff were working late within the practice and other staff had left. The staff were advised to escort patients to the front entrance to ensure they safely left the building. We did not find evidence of how this was being monitored.

Staff told us they received information regarding national patient safety alerts and medication alerts via email into the practice. The practice had a process in place for recording when action was required and who was responsible for these actions. The staff we spoke to were aware of their responsibilities to raise concerns, and told us they reported these to the practice manager.

Learning and improvement from safety incidents

National patient safety alerts were disseminated in paper format and electronically to staff. The practice nurse was able to give an example of a recent communication regarding Ebola preparedness and the action they had taken. We saw a process in place to ensure alerts were disseminated to the clinical staff within the practice and a record of actions taken.

We saw the practice had a policy in place for reporting significant events, incidents and accidents. However we saw that the policy was not being followed. The practice manager was unable to show us a record of incidents that had occurred over the past 12 months. The practice had developed a risk register which showed who the responsible person was for each action. An example of this was lone working, when staff were working late within the practice and other staff had left. The staff were advised to escort patients to the front entrance to ensure they safely left the building. We did not find evidence of how this was being monitored.

During our visit in January several staff informed us of a medication prescribing error. We could not find any recorded evidence of an investigation being undertaken or learning actions identified. The practice manager told us they had investigated the incident and interviewed staff. This had not been recorded as a significant event. Our concern was that the practice had not demonstrated its understanding of significant events and may not recognise them when they occur. We would have expected a number of significant events to be recorded for a practice of this size.

We saw that following the interruption to power in the practice during May/June 2014 the practice had undertaken a root cause analysis and identified several actions and learning.

Reliable safety systems and processes including safeguarding

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to report information of concern to the practice lead or other relevant agencies. A safeguarding policy and contact details were accessible to staff.

The practice GP was the dedicated GP lead in safeguarding vulnerable adults and children. GPs were required to be trained (to Level 3) in order for them to fulfil their role as safeguarding lead. The GP had a good knowledge of safeguarding. We were told the practice nurse had not completed safeguarding training since joining the practice in July 2014, however we spoke with the practice nurse

who had a good knowledge of all aspects of safeguarding. They told us they intended to complete this training shortly. The practice manager and the reception/administration staff had completed on-line training in safeguarding adults and children. They had a good knowledge and awareness of the importance of safeguarding vulnerable adults and children.

The practice had a chaperone policy in place and there were notices displayed throughout the practice informing patients that this service was available. Some of the staff we spoke with told us they had received training in undertaking this role and there were sufficient staff available to undertake this role. The role was normally undertaken by the HCA.

Medicines management

Medicines stored in the treatment rooms and refrigerators were stored securely and were only accessible to authorised staff. There was a procedure for ensuring medicines were kept at the required temperatures and the action to take in the event of a potential failure. The vaccination fridge temperatures were recorded. However the fridge was not hard wired and notices advising staff not to remove the plug or turn the electric socket off were not displayed.

Processes were in place to check medicines were within their expiry date and suitable for use. The medicines we checked were within their expiry dates.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. The nurse had received appropriate training to administer vaccines. We saw the HCA also administered the flu and pneumococcal vaccines. The HCA had completed training in 2010 /11. However they had not received an update since 2013. We saw one entry in a patient's notes from the GP requesting the HCA give a specific medicine by injection which was not a vaccine. Patient specific directions are written instructions from a doctor for a medicine to be supplied or administered to a named patient. The practice manager was unable to provide any guidance or policy relating to this procedure.

We spoke with the HCA about the process they would follow and how they would deal with emergencies that may arise. We were assured that they would maintain patient safety and take appropriate action in an emergency.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We were aware there had been an incident when a repeat prescription for a medicine had been issued to a patient that had previously been stopped. We asked the practice manager for a copy of any medication errors that had occurred in the practice. However this information was not made available to us. Blank prescription forms were handled in accordance with national guidance; these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. 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.

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. Staff confirmed they had completed training in infection prevention and control. We saw that processes were in place for the practice to regularly check the level of cleanliness and infection control audits were undertaken regularly.

Staff told us there was always sufficient personal protective equipment (PPE) available for them to use, including masks, disposable gloves and aprons. We saw hand wash; disposable towels and hand gel dispensers were readily available for staff. However we noted hand gel was not available in the reception area of the practice.

Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor.

Staff told us the equipment used for procedures such as cervical smear tests and for minor surgery was disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We checked a number of disposable items that were all in date. Other equipment used in the practice was clean.

Equipment

Inadequate

Are services safe?

Staff we spoke with told us they had some equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was checked annually and we saw records this was completed. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example we saw that the weighing scales were calibrated. At our visit on 21 January 2015 we were told that the spirometer was awaiting repair and had been for some time. When we visited in March 2015 the equipment was still waiting repair and calibration. We were told this was because the repair company requesting payment in advance. The practice manager told us this had now been addressed and they were just waiting for the company to repair the equipment. The practice nurse told us she had only been able to use a hand held peak flow device during this time, which they used to assess the patient as part of the diagnosis process. A peak flow meter is used to measure the fastest rate of air you can blow out of your lungs and is frequently used by asthma suffers to monitor their breathing. Spirometry is a test that can help diagnose various lung conditions such as COPD. Spirometry is also used to monitor the severity of some lung conditions and their response to treatment. This meant that there was a potential impact on the health and care for patients with certain lung conditions as they could not be diagnosed, treated or monitored fully by the practice during the period when the spirometer was not working.

Staffing and recruitment

The practice manager told us the practice has been unable to recruit any further GPs. There is one single handed GP for 4500 patients and the practice relied upon locum GPs to provide support. We saw the turnover of locum GPs in the past year had been frequent. The locums we spoke with told us they found the work load busy and there was little support from the single handed GP. In October and part of November there had been only the single handed GP working to provide cover for 4500 patients and no locum cover. It was unclear why the practice had been unable to source a locum GP during that time.

Patients we spoke with told us they found the frequent turnover of GPs and other staff difficult as there was little continuity of care. We saw there had been a turnover of the nursing staff in 2014.The practice nurse who we spoke with at our inspection visits in January and March 2015 told us they were leaving on 13 March 2015. The practice manager told us they had been unable to secure another practice nurse permanently. We found there was limited monitoring of staffing levels and poor skill mix management on an ongoing basis.

The practice nurse was responsible for completing annual reviews for patients with long term conditions (LTC) and they were supported by one HCA. We were concerned the practice nurse and HCA were not fully supported in their roles and at times were working beyond their capabilities and training. We looked at 20 patient care records and saw examples where the nurse and HCA were working beyond their level of knowledge, training and expertise. Examples of these were advice and referral information given to a patient with no documented consultation with the GP or follow up of the patient. We also saw some advice given which did not follow National Institute for Health and Care Excellence, (NICE) guidance. Information was not provided to the patient about what to do in an emergency, nor if their symptoms worsened.

The practice had a recruitment policy which they had reviewed in Dec 2014. It outlined the process for appointing staff. The pre-employment checks that should be completed for a successful applicant before they started work in the practice. Staff who had been employed recently described the recruitment process and confirmed checks had been carried out prior to them starting work. We noted there was no record of the interview process in the practice nurses' file. We discussed the recruitment process with the practice manager. They confirmed that in the past they had not followed all the processes but were now adhering to the recruitment policy.

When we visited the practice in January we looked at the indemnity cover for the locum GP employed at that time. We noted it did not provide appropriate cover for the work they were undertaking. We discussed this with the practice manager and the locum and it was addressed immediately. At the March inspection visit there was a new locum GP. We were concerned that the indemnity cover the practice had checked for this GP was one year out of date. The practice manager confirmed that they had looked at this certificate but accepted that the locum agency had told them the GP had indemnity cover for the sessions required. We spoke with the locum GP and this was addressed whilst we were

in the practice. This demonstrated that previous lessons had not been learnt and procedures not adhered to when checking the indemnity cover for the locum GP employed at the practice.

The locum GP had been in employed at the practice for ten days and had not met with the GP lead. During our visit we observed them meeting and introducing themselves during a fire practice evacuation. It was therefore uncertain if the lead GP had been involved in the recruitment, induction, support or supervision of this locum GP. We asked the locum GP who told us they had received an induction from the practice manager. There was an induction pack available for locum GPs with limited information. There was no indication as to how the locum would access professional support and direction from the lead GP. In the 20 patient records we looked at during the inspection; we saw four records where the lack of information would have made it difficult for another GP, to take over their care.

Monitoring safety and responding to risk

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with cardiac problems whose health had deteriorated suddenly. This included supporting them to access emergency care and treatment.

There was a health and safety policy and the practice manager took the lead for health and safety in the practice. Some risk assessments had been completed to identify any significant risks and the measures required to reduce harm occurring. However these were not dated. The practice manager told us they regularly monitored risks to patients, staff and visitors to the practice. For example they completed periodic checks of the building and the environment which would identify any risks. We did not see documentation of these checks but other staff confirmed they took place.

The practice was located in a health centre that was shared with other GP practices and services. This was maintained and cleaned by an external company. We saw evidence that maintenance was undertaken as required, for example for gas, electric and fire safety systems. There was a process in place for staff to report any faults or problems and they confirmed issues were dealt with regarding these areas in a timely manner**.**

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We found the practice had emergency airway equipment and medicines available to be used in an emergency; these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. The medicines we checked were in date and fit for use. The practice had oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Records showed all staff had received training in basic life support. The staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. Staff we spoke with knew the location of the emergency airway equipment and medicines. Records confirmed that it was checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned staff sickness and access to the building. The document also contained relevant contact details for staff to refer to. However not all the staff we spoke with were aware of, nor understood the business continuity plan or what actions they would need to take.

The practice had carried out a fire risk assessment. It 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. During our visit on 10 March 2015 we observed a fire evacuation drill for the building.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff told us they were familiar with current best practice guidance; accessing guidelines from the National Institute for Health and Care Excellence (NICE). They told us NICE guidance was received into the practice via email and then disseminated to GP and nurse. It was unclear if there was a structured approach to dealing with best practice guidance to ensure it was discussed and any required actions agreed.

Due to information of concern received by CQC a decision was made to review a sample of patient records. Two GP specialist advisors reviewed the records of 20 patients. We looked at the availability of appointments and care delivered. We looked at which clinician had seen the patient and if care was delivered in accordance with national guidance and current best practice. We found some instances of concern in the care and treatment in the patient records we looked at.

We found eight occurrences where current best practice was not being followed. Examples of these were medicines, prescribed treatments and lack of further investigations or follow up. We also saw that the rationale for some decisions was not given or not clearly documented. This made taking over care for another clinician difficult and may impact on the continuity of care. Examples of these included treatments, medication or lack of referral for further investigation or treatments. There were several instances where we could find no documented evidence that patients were advised what they should do if their condition deteriorated nor had they been involved in formulating a plan. In one patient record we saw that there was a discharge letter dated the 27 October we saw that this letter had not been signed off by the GP until 14 November 2014. This meant that there was a risk that important information about the patient's hospital admission and treatment may be delayed**.**

We found two instances where the two specialist advisor GPs thought a recall of the patient was urgent. An example of this was the indication of a need for a two week referral to secondary care and another was to recall a patient following a consultation with the health care assistant. We requested to speak with the lead GP to pass on this information but were told they were too busy to speak with us or to receive feedback about the overall findings of the inspection. The lead GP agreed later, to speak with one of the GP advisors and the inspection manager in relation to one of the patients that had been identified by GP specialist advisor as requiring an urgent referral to secondary care. The lead GP later told us the patient had been checked and there was now no indication for an urgent referral.

The practice had agreed to deliver the enhanced service to identify patients at higher risk of being admitted to hospital as an emergency and had identified 96 patients. These 96 patients had care plans in place. We were told that patients were offered a copy of their care plan however the practice was unable to tell us how many had taken up this offer.

The practice nurse described how they carried out comprehensive assessments and reviews for patients with long term conditions (LTCs). They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. Feedback from patients confirmed they were referred to other services or hospital when required.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GP we spoke with used national standards for the referral of patients, for example for patients with suspected cancers were referred and seen within two weeks.

The national data also showed that the practice's performance for prescribing was within expected ranges, for example for antibiotics and anti-inflammatory medicines.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice manager and lead GP were responsible for the management of the information submitted for the quality and outcomes framework (QOF), a national performance measurement tool for general practices. We reviewed the practice performance for the previous year and found that the practice was performing well within the CCG average in

some areas of the QOF. We saw only one area of risk identified were the practice was below the England mean average which was the reported prevalence of Coronary Heart Disease (CHD) which was 4.9% compared to the national mean average of 7.9%. We saw during our visit in March that the practice was in the process of reviewing QOF and recalling patients for review and assessment, to action any outstanding areas of the QOF.

The practice manager provided a copy of two clinical audits that had been completed. However on review we saw one of these was not a clinical audit but a review of repeat prescribing. The clinical audit looked at self-monitoring of blood glucose and was informed by NICE guidance and identified cost savings and other initiatives to improve patient care of this patient group. This audit had been completed in February 2014. The other audit we received was a review of repeat prescribing and a list of the costs of medicines. There was no detailed information to establish what the outcome of this review was or if over ordering of prescriptions had been reduced. We spoke with the nurse and HCA who confirmed they were not involved in clinical audits and were not aware of any improvements made as a result of any audit.

We saw the practice nurse was undertaking all childhood immunisations. The immunisation rates for the practice were not made available to us despite requesting this information on our inspection visits. We saw the current nurse was not qualified to undertake cervical smears and had been planning to undertake a course to address this before their decision to leave. We noted that the lead GP currently undertook all smears required in the practice.

There was a protocol for repeat prescribing which was in line with national guidance. We were told that medicine alerts coming into the practice were distributed to the clinical staff and any changes required were highlighted. The practice manager told us that any changes and actions required were documented. The practice nurse and HCA were able to give examples of recent medicines alerts.

The practice had a palliative care register and had regular meetings which included members of the multi-disciplinary team to discuss the care and support needs of patients and their families. We found the minutes of these meetings contained patient identifiable information such as their full name date of birth and address. In the October 2014 meeting minutes we saw a patients decision for do not resuscitate (DNAR) was discussed and a request was made to email the end of life nurse for clarification. In the November 2014 minutes there was the same entry suggesting that the DNAR status had not been followed up. The practice manager was unable to provided clarification about this issue.

The lead GP in the practice held minor surgical and joint injections clinics once a fortnight. The procedures were not made available to check if they were in line with NICE guidance. There were no audits undertaken to monitor the effectiveness or any infection following these procedures.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed six staff files and were able to find evidence that staff were up to date with essential training, for example cardio pulmonary resuscitation and safeguarding adults and children. The practice manager told us they had a training manager and planned to complete a training matrix which would outline what training each member of staff required, when they had attended, or when due refresher training.

The practice had an induction programme in place for new staff which covered generic issues such as fire safety and infection control. A comprehensive staff handbook had been developed which would support new staff. We did not see any role specific induction in place.

The practice was a single handed GP practice; there was one practice nurse and one HCA. The practice received clinical input from a locum GP on Mondays, Tuesdays and Wednesdays. We had concerns that the level of clinical input in the practice was insufficient to meet the needs of a practice population of 4500. We were told the practice had been unable to recruit any further GPs.

The GP we spoke with was up to date with their annual continuing professional development requirements and they had been revalidated in 2014. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed with the General Medical Council and then NHS England can the GP continue to practise and remain on the performers list).

The GP and practice nurse were registered with their respective professional bodies such as the General Medical Council. There were processes in place to check that doctors and nurses were meeting the requirement to

remain registered with their professional bodies, and therefore were still deemed fit to practise. This decreased the risk of registration lapsing for those staff that should only provide care and treatment whilst registered with a professional body. We noted that the practice had not always checked the medical indemnity cover for GP locums, and nurses. Adequate insurance or indemnity provides patients with the assurance that they will not be disadvantaged if they make a claim about the clinical care they have received.

We saw all staff permanently employed within the practice had received an appraisal. The staff we spoke with were positive about the experience. We found evidence to confirm appraisals had been completed.

The nurse told us they did not have formal clinical supervision sessions. However, they discussed their clinical practice with district nurses. The nurse told us they met with the district nurses monthly and found this a supportive experience. The nurse also provided support to the HCA. The HCA confirmed they regularly met with the practice nurse to discuss their practice. There were no records of the HCAs competency being observed or assessed by the nurse or the lead GP. The practice nurse told us she had not observed the competency of the HCA. The HCA told us she had not been observed in the last year.

Working with colleagues and other services

Staff told us that they met regularly with staff from palliative care and community services to discuss how individual patients' needs would be met. We saw evidence the practice staff worked with other professionals. During our visit we spoke with a representative of the community mental health team, who was positive about the working relationship with the practice. Minutes from meetings confirmed that community nurses and palliative care nurses attended to discuss treatment and care of patients with complex needs to ensure they were being met.

An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We were told by the administration staff that note summarising had not taken place in the practice since January 2015.

There is risk that important information will be delayed in being entered into patient's electronic record. We were told that staff would be undertaking further training in March to enable them to undertake this process. Note summarising is the transferring of medical information from a patient's paper records to an electronic medical record.

We saw that when letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service were received both electronically and by post they were scanned into the patient's record. We were told that the administration staff read post received from secondary care such discharge notifications and decide which the GPs need to see urgently. We were unable to establish what training the staff had received to undertake this process safely and effectively. Staff told us this was not overseen by the GPs. An audit of discharge correspondence had not been undertaken by a clinical member of staff to ensure that errors had not occurred. There was a risk that important information might not be reviewed and acted upon by a clinician.

There was an electronic system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care.

Information sharing

The practice used several 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. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

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. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Staff described how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear

understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and then documented in the electronic patient notes. Patients we spoke with confirmed they had been sent a consent form to complete before the procedure. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

Health promotion and prevention

The provider offered all new patients a consultation to assess their past medical and social histories and care needs. Following the assessment care would be arranged that met the patients' individual needs. Staff used their face to face contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic vaccinations and smoking cessation advice to smokers.

The practice identified which patients attending the practice had a caring role. We saw limited information about carers support groups available in the waiting area for patients. The practice had registers of patients with certain conditions such as patients with learning disabilities, dementia and mental health issues.

We saw limited health promotion information available in the waiting room and there was no information on the practice website. We saw that further information was available in consulting rooms for clinicians to hand out to patients. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

The practice had numerous ways of identifying patients who needed additional support. The QOF data showed that the practice was performing well in identifying the smoking status of patients over the age of 16 and was actively offering smoking cessation support and advice to these patients.

The practice's performance for cervical smear uptake was 88.22 %, which was above national and CCG area average. We did not see any auditing of the quality of the cervical smears undertaken.

The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. The practice nurse held an immunisation clinic every Wednesday morning and the HCA offered flu vaccination to older people. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding September to 31 March was 98.4% which is above the national average.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were familiar with the steps they needed to take to protect patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting 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 and that conversations taking place in these rooms could not be overheard.

We reviewed the most recent data available from the national patient survey for the practice on patient satisfaction. This showed 80% of respondents stated that the last GP they saw or spoke to was good at treating them with care and concern, and 86% said the GP was good at listening to them. The satisfaction rates for the nurses for these two areas was: 88% stated the nurse was good, at treating them with care and concern and 94% said the last nurse they saw or spoke to was good at listening to them.

We spoke with seven patients during the inspection and received 11 completed CQC comment cards. Feedback received from the CQC cards was mixed with seven patients making positive comments about the staff being good, helpful and treating them with dignity and respect. Feedback from four patients was negative they said the service they received was poor and access to appointments difficult.

We observed reception staff treating patients with respect and being helpful and supportive. The practice had an open plan reception area and we observed reception staff were discreet and quiet when speaking with patients. There was a room available if patients wished to discuss a matter with the reception staff in private. The door to the back office was kept closed to avoid patients being able to overhear telephone conversations. However due to the close proximity of the reception desks to the seating area discussions between staff and patients could be overheard.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed mixed responses from patients to questions about their involvement in planning and making decisions about their care and treatment. For example, the most recent data from the national patient survey showed 67% of respondents said the GP involved them in care decisions. The national average was 81%. 78% felt the GP was good at explaining treatment and results. Patient responses regarding the nurses was positive in these areas with 87 % of respondents saying the nurse involved them in care decisions. The national average was 85% and 94% felt the nurse was good at explaining treatment and results.

Most patients we spoke to on the day of our inspection told us that health issues were discussed with them. They felt involved in decision making about the care and the treatment they received. However we saw in patient records discussions and involvement with patients in making decisions was not always clearly documented. We were told by patients they felt listened to and supported by staff. Patient feedback on the comment cards we received aligned with these views

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 patients this service was available. However in one of the patient records we looked at we saw that it had been highlighted in a child's record that the mother had difficulty in understanding English. At a further appointment for the child no interpreter had been booked. We saw no explanation as to why this had not been actioned or how the clinician dealt with the mother's lack of understanding of English.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Feedback from the comment cards and the patients we spoke with on the day was mainly positive. They said they had received help to access support services to help them manage their treatment and care when it had been needed. For example, staff responded compassionately when they needed help and provided support when required. They told us they found the clinical staff excellent and the reception staff helpful. However patients commented on the continual changes in clinical staff which made it difficult for continuity of their care.

Requires improvement

Are services caring?

Staff told us that if families had suffered bereavement they send a card to offer their sympathy and support. Patients who were on the end of life register who had died would be discussed at the end of life care meeting. The family would be followed up to offer support during their bereavement.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was not always able to respond effectively to people's needs and demands. The practice had implemented some suggestions for improvements and made some changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, in the 2012/13 PPG annual report the practice had tried to improve privacy at reception by ensuring the door between the reception and office was kept closed to avoid patients overhearing information. The practice had tried to address unnecessary attendance at A&E by sending out letters to patients who visited A&E. Informing patients that visits to A&E incurred a cost of £100 to the practice. This initiative had stopped; the practice manager told us that patients had complained. We were told that they now try and speak to the patients concerned in person when they next visited the practice. The members of the PPG we spoke with told us they do not feel the practice listened to the concerns they raised on behalf of patients. They were unaware of any recent improvements that had been made in response to any suggestions they had made.

The staff composition of only one GP had remained stable over the past 12 months and patients told us they thought this impacted on the care for patients. We continued to receive concerns from patients since our inspection in June 2014, who were unhappy with the service and the continual changes in staffing. Patients told us there was a lack of continuity of care with different clinicians. The practice were using locum GPs to cover appointments. We were told by the practice manager that it was becoming more difficult to get locum cover. We were told that a sessional GP left the practice in September 2014 and the practice was unable to find a locum until November 2014. It was unclear if during that time the practice had been able to recruit any short term locum cover. The GP lead had provided cover five days a week until the new locum joined the practice in November 2014. The practice had only one practice nurse and a HCA supporting the GP. During this time we received concerns from patients about the difficulty in accessing appointments.

The practice offered 10 minute appointments. However longer appointments were available for people who needed them. Twenty minute appointments were offered to patients with long term conditions or complex health issues. We were told that there were very few home visits made. However we saw this service was offered to those patients who could not attend the surgery.

The lead GP told us they used telephone triaging, if required the patient was then offered an appointment. We were told this allowed the practice to increase the number of patients who were offered an appointment. The patients we spoke with and the patient records we reviewed confirmed this.

The practice struggled to maintain the level of service required for 4500 patients. The needs of the practice population were not clearly understood by staff and systems were not in place to effectively address identified needs. There was no evidence the practice used any risk tools to help the practice detect and prevent unwanted outcomes for patients.

The lead GP told us they did not actively engaged with the Clinical Commissioning Group (CCG). The practice is situated within a health centre with other GP practices and services. There was no evidence of joint working with other practices in the building as we were told there was on going disputes between the practices located within the health centre.

Tackling inequity and promoting equality

The practice gave longer appointment times for patients with learning disabilities and those who required one. The practice had access to translation services if required and the staff we spoke with were aware of these. The practice manager told us they had an increased number of patients from eastern European origins who had joined the practice.

The premises and services had been designed to meet the needs of people with disabilities. We found the practice and consulting rooms were accessible to patients with mobility difficulties. All facilities were on the ground floor. The one toilet in the practice which was used for patients and staff was not accessible for people with disabilities. However, there were disabled accessible toilets in the entrance to the building which was shared with other practices and health services. There was a waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that they did not have any patients who were of "no fixed abode". The practice manager told us that they did see them as temporary patients.

Access to the service

Patients could make appointments either by telephone or by coming to the practice. The practice was open from 08.00hrs to 19.30hrs Monday and Thursday. On Tuesday, Wednesdays and Friday the practice is open from 08.00hrs to 18.30hrs. National Patient survey data for 2014 indicated 87% of patients were satisfied with the surgery opening hours. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. However patients could only book an appointment a week in advance and patients were unable to see a GP of their choice. Appointments with the nurse could be booked a month in advance. The national GP Patient survey data for 2014 showed that only 44% of respondents with a preferred GP could usually get to see or speak to that GP. Patients also expressed dissatisfaction with the changing clinical personnel during 2014 and 2015. These included locum GPs and nurses as a number of staff had left the practice. The lead GP did not work on Mondays and finished their surgeries at 3.30pm on Tuesday and Wednesday and was available after that time via the telephone.

Patients we spoke with, and feedback from CQC comment cards confirmed that patients currently found it difficult to get appointments when they needed them. This included same day appointments. We found patients were not satisfied with the appointment system at the practice. The lead GP said if a patient needed an urgent appointment during the afternoon and all the slots had been taken then they spoke with the patient on the telephone to determine if they needed to be seen that day. The practice did not have a policy to offer appointments outside of school hours for children and young people. Two patients told us they often experienced difficulty accessing appointments for their children. We saw on two occasions that a child and young people had been seen by a practice nurse. However they had not been trained in triaging or assessing this population group.

Comments received from patients showed the majority of patients in urgent need of treatment had been able to make appointments on the same day they contacted the practice. This was observed on the day of the inspection where receptionists tried to facilitate patient's needs. One patient told us they had only been offered an afternoon triage appointment with the nurse, who would not be able to issue a prescription, if needed. The patient had been told that the GP was not available. The patient was not happy with this process and the limited access to care they felt they required.

Longer appointments were available for older people, those experiencing poor mental health and patients with long-term conditions. Home visits were made to local care homes by the GP and to those patients who could not attend the surgery.

The practice provided a large number of telephone consultation appointments which enabled the single handed lead GP to assess patients when clinical staffing was reduced. This was due to an inability to access a locum GP to work in the practice. Patients who worked during the day or were unable to get to the practice did not have a choice of how they made their appointments. Online appointment booking was not yet available. The practice was preparing to offer online appointments and repeat prescription requests to all patients, who wished to use this service. We checked the practice web site in April which has not been updated to reflect that the practice are now offering online services to all patients.

Information about appointments was available to patients on the practice website. However the practice web site was not up to date.

We did not see information leaflets for patients on what to do in an emergency, in hours and out of hours nor, how to arrange urgent appointments and home visits. This information was also not available on the practice website. We were told that if patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Copies of the practice information leaflet were not available for patients in the waiting area. We were not provided with this when we requested it.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The policy needed to be updated to reflect current organisational changes as it still referred to the primary care trust.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Information on how to make a complaint was not available on the practice website. However information about how to make a complaint was available and displayed in the waiting room. We saw that the complaints policy had details of who patients should contact and the timescales when they would receive a response.

Patients we spoke with told us they were not aware of the complaints procedure but if they were not happy with something they would raise it with a member of staff. Two of the patients we spoke had made a complaint about the practice and we were told it was investigated and resolved. Staff we spoke with were aware of the practice complaints procedure and described how they would support someone who was not happy with the service.

The practice had received nine complaints in 2014 and we saw that they had investigated the complaints and responded to the complainant in a timely manner.

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 staff told us they wanted to deliver good quality care. The practice manager told us this had been difficult to achieve due to the many staff changes and the inability to employ a permanent GP. There were no details of the practice vision and practice values displayed in the waiting area or on the practice website. The practice mission statement was displayed on the practice website. The staff we spoke with were unable to describe the practices vision or mission statement. It was evident the practice lacked any vision or strategy about how it would deal with current and future changes and demand.

Governance arrangements

The practice team was small but there were named members of staff in lead roles. For example, we saw that there was a named lead for Infection Prevention and Control (IPC) and the GP was the safeguarding lead. The staff we spoke with confirmed this was correct.

There were a number of policies and procedures in place to govern activity, for example infection control, medicines management and information security. We saw that policies had been updated and reviewed. We also saw policies which had been missing when we inspected in June had been developed. We saw the recruitment policy had been reviewed since our last visit and so had induction programmes for staff.

All of the staff we spoke with knew who to go to in the practice if they had any concerns and said they felt supported by the practice manager. The staff told us they had regular staff meetings, However only one set of practice meeting minutes were available. The practice manager confirmed there had been only one meeting since our visit in June 2014. However staff told us that the practice manager communicated and kept them updated with changes in the practice. As the practice was small they felt it was easy to communicate with staff regularly. This system did not provide a process for documenting who was responsible for any identified actions.

The QOF data for this practice showed it was performing well within the CCG average in a number of areas. The practice was currently reviewing QOF and sending out reminders to patients about reviews. On the final visit the lead GP told the inspection team that they were too busy to receive feedback and findings from the inspection as they were busy checking QOF.

There was little evidence of any benchmarking or peer review activity with other practices.

The practice did not have an ongoing programme of clinical audits to monitor quality or systems in place to identify where action should be taken to improve service delivery.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues with the practice manager and report incidents The practice manager told us they use the datex system to report incidents. Datex is an incident and adverse events reporting system. However the practice manager was unable to provide or retrieve any information inputted by the practice. It was difficult to establish how the practice learnt from, share with staff and prevented further incidents occurring when they were unable to retrieve information.

We saw that following the interruption to power in the practice during May 2014 the practice had undertaken a root cause analysis and identified several actions. Examples included improving communication between Ashwood Surgery limited and other practices within the health centre. A review of the business continuity plan to ensure staff were aware of what action to take in the event of disruption to all aspects of the service. Improved staff awareness of the importance of maintaining the cold chain and how to deal effectively and safely with interruptions to the cold chain. The clinical staff confirmed they were now aware of the cold chain process and what to do in the event of a problem.

We saw the business continuity plan had been reviewed. However the staff we spoke with were not fully aware of the plan or their role.

The practice did not have regular practice meetings. Minutes of this meeting showed no clear actions or named member of staff identified who was accountable for taking forward any actions resulting from this meeting

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Are services well-led?

Inadequate

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

The practice manager was responsible for human resource procedures. We saw that there was an induction procedure in place and policies for disciplinary issues and whistleblowing. The practice had access to an external HR company to support them with staff issues and promote their positive wellbeing.

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

The practice had established a Patient Participation Group (PPG) and they had held four meetings in 2014. The last available minutes available were 23/7/2014. We saw an agenda available for a planned meeting in March 2015. The PPG members we spoke with were unclear about when the last meeting had occurred. It was unclear from the minutes how feedback was used to improve services. The PPG members we spoke with told us, they shared with the practice, the concerns and dissatisfaction they had received from patients. Examples of these were access to appointments, no GP available when the practice is open late on one of the evenings and the frequent changes in staffing. However they felt these concerns were not listened to or acted upon

We found that the practice had undertaken surveys to gather feedback from patients. We saw that they had developed actions to address issues raised from patient feedback. There were no dates to indicate when these actions would be completed or who would be responsible for implementation.

Examples of some actions taken by the practice following feedback were more appointments being made available and patients to be informed if appointments were running late via the electronic communication board in the waiting area. On our visits in January and March the board was not in use and there was not an alternative system in place to keep patients informed of any delays.

We saw a suggestion box was available in the reception area and forms for recommending family and friends.

We did not see any evidence that staff surveys were undertaken but staff told us they could raise any issues with the GP and practice manager.

Management lead through learning and improvement

The practice had an understanding of the need to ensure staff had access to learning and improvement opportunities. Since our visit in June 2014 we saw that staff had completed further training. Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. However we saw the HCA had not received any updates for administering flu and pneumococcal vaccines or ear syringing since 2013. There was no evidence that the competency of the member of staff had been observed. The appraisal process gave staff the opportunity to develop a personal development plan. Staff told us the practice supported them to undertake training. We saw all permanent staff had been appraised in the past 12 months. Staff told us they had access to training.

There was no evidence the practice led through learning and improvement. The practice could not provide evidence of completed audit cycles other than one where the first cycle of an audit was completed in 2014. The practice had not completed reviews of significant events and other incidents in the last 24 months.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe.** **This breach corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Assessing and monitoring the quality of service provision.** **Governance arrangements were not sufficient to protect patients and others from inappropriate or unsafe care. Unforeseen events and recruitment of staff were not adequately managed.** **Systems to monitor performance and service quality were not robust. There was limited use of audit, patient feedback and performance information to drive improvement.** **This breach corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Compliance actions

Surgical procedures

Treatment of disease, disorder or injury

The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported and trained in relation to their responsibilities, to enable them to deliver care and treatment to patients safely

This breach corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.