Dr Paul Unyolo

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?	Requires improvement
Are services caring?	Good
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 Dr Paul Unyolo (Talke Clinic) on 30 September 2015. This inspection was undertaken to check the practice was meeting regulations and to consider whether sufficient improvements had been made since our last inspection in February 2015.

Our inspection in February found breaches of regulations relating to the safe, effective and well-led delivery of services. As a result of these the practice was rated as inadequate for providing well-led services and requires improvement for providing safe and effective services.

Following the publication of the report in June 2015, we received an action plan which detailed the actions to be taken to achieve compliance. At our inspection in September 2015 we found that the practice had made improvements in some areas and was meeting regulations that had previously been breached. However, further breaches were identified.

Overall the practice is rated as inadequate.

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

- Staff generally understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. However, information about safety was not always properly recorded, monitored, appropriately reviewed and addressed. There was limited evidence of learning from significant events and complaints. Discussions with staff were not always documented.
- There was no system to ensure all clinicians were kept up to date with national guidance and guidelines.
- Safeguarding arrangements to protect children and vulnerable adults within the practice were not robust. Children considered by the practice to be at risk of abuse had not been reviewed or followed up appropriately.
- Patients and staff were at risk of harm because systems and processes were not in place to keep them safe.

Summary of findings

- Data showed patient outcomes were in line with the average for the locality. Although some audits had been carried out, we saw limited evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested and most patients we spoke with were happy with access to the practice.
- The practice had a number of policies and procedures to govern activity, but there was no clear system in place to review and update these.
- Whilst the practice had a leadership structure, we found there was insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Put systems in place to ensure that children and vulnerable adults are protected from harm.
- Ensure Disclosure and Barring Service (DBS) checks are undertaken for all staff or where these are not undertaken, a risk assessment is in place.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Take action to address identified concerns with infection prevention and control practice.

In addition the provider should:

- Strengthen their programme of clinical audit to ensure audits are sufficiently detailed, reference national guidelines and drive improvement within the practice.
- Consider whether there is leadership capacity to deliver all improvements
- Ensure all staff have appropriate policies, procedures and guidance to carry out their role.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This could lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. We identified complaints which should have been recorded and investigated as significant events by the practice.

Patients were at risk of harm because systems and processes were not in place to keep them safe. The practice did not have robust arrangements in place to ensure that children and vulnerable adults were protected from harm. For example, the list of children at risk was not regularly reviewed and the practice did not hold regular safeguarding meetings.

The practice did not have a named infection control lead and had not conducted an infection control audit since June 2014.

There was insufficient information to enable us to understand and be assured about safety because the practice did not have a completed health and safety policy. The health and safety policy reviewed had not been personalised to the practice or approved and remained in a draft format. In addition to this the practice had not undertaken risk assessments in relation to health and safety since December 2013. The practice had no business continuity plan in place.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. However the lead GP and salaried GP rarely worked within the practice at the same time. This meant clinical meetings were held in the absence of the salaried GP meaning we could not be assured of the robust dissemination of information.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams but some of this was informal and not documented.

Summary of findings

There was limited evidence that clinical audit was being used to drive improvement. Some of the audits we reviewed did not reference national guidelines and were not sufficiently detailed.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care especially in respect of satisfaction scores for consultations with GPs. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Feedback from patients we spoke with on the day and from completed CQC comment cards was positive about the caring service staff provided.

The practice did not use care planning for patients on the palliative care register so did not have information recorded about patients' wishes at end of life.

Are services responsive to people's needs?

Requires improvement

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care especially in respect of satisfaction scores for consultations with GPs. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Feedback from patients we spoke with on the day and from completed CQC comment cards was positive about the caring service staff provided.

The practice did not use care planning for patients on the palliative care register so did not have information recorded about patients' wishes at end of life.

Are services well-led?

Inadequate

The practice is rated as being inadequate for being well-led. The practice did not have a documented strategy, although staff we spoke with shared the values of the practice to care for patients.

The practice had a leadership structure in place but there was little delegation of responsibility with the majority of lead roles assumed

Summary of findings

by the lead GP or the practice manager. We had concerns around leadership capacity. These stemmed from the fact that improvements had not been made in a number of areas since our previous inspection in February 2015.

The practice had policies and procedures in place to govern activity but some policies had not been completed or approved. The practice did not always ensure its own policies were followed, for example in relation to seeking criminal background checks for all staff as indicated in their adult protection policy.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice was rated inadequate overall. The concerns which led to this rating apply to everyone using the practice including this population group.

Data provided by the practice showed that outcomes for patients were generally good for conditions commonly found in older people. Patients over 75 were allocated a named accountable GP. The practice had identified 333 patients over 75.

The practice offered flexible appointment times for this group of patients to ensure that carers could attend if required. Home visits were also offered to enable monitoring of long term conditions and administer flu vaccinations.

The practice had recently introduced more regular visits to their local care home.

Older patients we spoke with during our inspection were happy with the level of care and treatment they received.

People with long term conditions

Inadequate

The practice was rated inadequate overall. The concerns which led to this rating apply to everyone using the practice including this population group.

Nursing staff had lead roles in the management of chronic diseases and patients at risk of hospital admission were identified as a priority. The practice offered patients with multiple long-term conditions holistic reviews rather reviews at separate disease clinics. The practice offered different appointment lengths dependant on the type of chronic disease monitoring.

The practice told us that hospital discharges and attendances at A&E were monitored to flag any exacerbations of chronic diseases. Homes visits were offered for this group of patients were these were required.

Practice supplied QOF data for 2014/15 showed that there had been improvements in their performance in respect of long term conditions. For example, practice achievement in respect of diabetes related indicators had increased from 75.8% to 80.8%.

Families, children and young people

Inadequate

The practice was rated inadequate overall. The concerns which led to this rating apply to everyone using the practice including this population group.

Summary of findings

The practice did not have robust systems in place to follow up children who were at risk. For example, we saw evidence that a child considered to be at risk had attended the practice recently and not been appropriately followed up. The practice did not hold formalised safeguarding meetings.

Child health clinics were run by community midwives from the practice and the practice arranged new baby clinics for the same day to facilitate new parents.

The practice aimed to offer flexible appointments to meet the needs of this population group.

Family planning advice and services were offered by the practice including coil insertion.

Working age people (including those recently retired and students)

Inadequate

The practice was rated inadequate overall. The concerns which led to this rating apply to everyone using the practice including this population group.

The practice offered flexible appointments to facilitate access for this group of patients. This included late evening appointments on a Monday evening and early morning appointments on a Thursday. Pre-bookable appointments were available 14 days in advance and patients could access urgent appointments on the day via a nurse-led triage service.

Online appointments were available along with online prescription ordering. The practice website offered a range of information about health promotion and the treatment of minor ailments.

NHS health checks were offered for patients aged 40-74.

People whose circumstances may make them vulnerable

Inadequate

The practice was rated inadequate overall. The concerns which led to this rating apply to everyone using the practice including this population group.

Patients on the learning disability register were pre-booked into appointment slots rather than going through triage slots. Waiting time for patients who had a learning disability was kept to a minimum to reduce patient anxiety.

The practice offered home visits for yearly learning disability checks unless the patient requested to come to the surgery.

Vulnerable patients were identified and flagged on the practice computer system. However, we saw evidence of an instance where a vulnerable patient had been referred to adult safeguarding and had

Summary of findings

not been appropriately followed up. Staff we spoke with knew how to recognise the signs of abuse in vulnerable adults but the practice policy in relation to adult protection needed to be reviewed and updated.

We saw that care planning was not being undertaken in respect of patients on the palliative care register.

Staff told us they would register patients who were homeless using the practice address if this was required.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice was rated inadequate overall. The concerns which led to this rating apply to everyone using the practice including this population group.

The practice had taken steps to improve performance in QOF in respect of mental health related indicators. The practice ensured that dementia and mental health reviews were performed along with any other required chronic disease health reviews to facilitate patients.

Home visits were offered to this group of patients when required.

The practice signposted patients experiencing poor mental health to various support groups and voluntary sector organisations. The practice had systems in place to follow up on A&E attendances.

Staff within the practice had completed dementia training.

Summary of findings

What people who use the service say

We reviewed the results of the national GP patient survey published in July 2015. Questionnaires were sent to 293 patients and 102 people responded. This was 35% response rate. The practice performed well when compared with the local and national averages in respect of the following areas:

- 86% of respondents found it easy to get through to the surgery by phone compared with a CCG average of 73% and a national average of 73%;
- 88% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care compared with a CCG average of 81% and a national average of 81%;
- 95% of respondents said the last GP they saw or spoke to was good at giving them enough time compared with a CCG average of 88% and a national average of 87%.

The practice did not perform as well in the following areas:

- 68% of respondents described their experience of making an appointment as good compared with a CCG average of 76% and a national average of 73%;
- 84% of respondents said the last nurse they saw or spoke to was good at giving them enough time compared with a CCG average of 92% and a national average of 92%;
- 77% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care compared with a CCG average of 85% and a national average: 85%.

We spoke with nine patients during our inspection in addition to a member of the PPG. Patients we spoke with were generally very positive about the practice. They told us they were treated with dignity and respect and did not feel rushed during appointments.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to the inspection. We received 17 completed comments cards. Fifteen of the cards were wholly positive about the standard of care and treatment received; patients said they were treated with dignity and respect and felt listened to. Two patients raised waiting times as an issue.

Areas for improvement

Action the service MUST take to improve

- Put systems in place to ensure that children and vulnerable adults are protected from harm.
- Ensure Disclosure and Barring Service (DBS) checks are undertaken for all staff or where these are not undertaken, a risk assessment is in place.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Take action to address identified concerns with infection prevention and control practice.

Action the service SHOULD take to improve

- Strengthen their programme of clinical audit to ensure audits are sufficiently detailed, reference national guidelines and drive improvement within the practice.
- Consider whether there is leadership capacity to deliver all improvements
- Ensure all staff have appropriate policies, procedures and guidance to carry out their role.

Dr Paul Unyolo

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor, a second CQC inspector, a CQC inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr Paul Unyolo

The practice provides primary medical services to a population of approximately 3740 patients through a general medical services contract (GMS). The practice is situated in the semi-rural village of Talke Pits in the borough of Newcastle under Lyme, Staffordshire.

The practice population live in an area of deprivation which is similar to the national average. The practice has a larger elderly population than the national average.

The practice currently has one principal GP (male) and two salaried GPs (female). The nursing team consists of one advanced nurse practitioner and one practice nurse (both female). The practice currently has a vacancy for a healthcare assistant. The clinical team is supported by a practice manager, an assistant practice manager and reception and administration staff.

The practice was open between 8.00am and 6.30pm Tuesday, Wednesday and Friday. The practice opened from 7.30am to 1.00pm on Thursday and from 8.00am to 8.00pm on Mondays. .

The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Staffordshire Doctors Urgent Care when the practice is closed.

Why we carried out this inspection

A comprehensive inspection of this practice was undertaken in February 2015. The practice was rated as requires improvement overall and was rated to be inadequate for providing well-led services.

The breaches of regulations identified on the previous inspection related to the safe, effective and well-led delivery of services.

We carried out a comprehensive inspection of this service to check whether the provider had made the required improvements and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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?

Detailed findings

- 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 30 September 2015. During our visit we spoke with a range of staff (GPs, nursing staff, the practice manager and administrative and reception staff) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risk and to improve patient safety, including patient safety alerts, complaints and significant events.

We saw evidence that the practice had a system in place to ensure that alerts related to patient safety and medications were disseminated within the practice and appropriately acted upon.

Following the previous inspection in February 2015, the practice had done some work to improve its recording and monitoring of significant events. We saw evidence that significant events were discussed at clinical meetings. However, we were not assured that the systems in place to record, investigate and learn from significant events and complaints were robust.

Staff we spoke with were aware of their responsibilities to raise concerns and could provide examples of significant events. However, the practice did not have systems in place to review complaints to determine if these should be considered as significant events. We identified two complaints which should have been considered by the practice as significant events. For example a complaint in relation to an alleged injury being sustained following a blood sample being taken.

The practice provided us with records of significant events and complaints and we reviewed minutes of meetings where these were discussed. In some cases the level of detail recorded in respect of the investigation was not sufficient. The system for recording the discussions around significant events in clinical meeting minutes meant it was unclear as to what had been discussed and agreed.

Overview of safety systems and processes

The practice had some embedded systems, processes and practices in place to keep people safe, which included:

- A notice was displayed on consulting and treatment room doors which advised patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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).
- Arrangements were in place to manage medicines, including emergency drugs and vaccinations to keep people safe (including obtaining, prescribing, recording, handling, storing and security). Staff told us that regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment in most instances. For example, proof of identification, references, qualifications and registration with the appropriate professional body. We saw that the practice had undertaken the appropriate checks through the Disclosure and Barring Service for clinical staff; however reception and administrative staff had not been checked. The practice had not assessed the risk that this could pose to patients.
- Arrangements were in place for planning and monitoring the number of staff and skill-mix needed to meet patients' needs. Clinical staff worked set hours each week. There was a rota system in place for administrative and reception staff to ensure that enough staff were on duty and staff worked overtime hours if this was required.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had made improvements following the last inspection to ensure that staff were protected against the risks of acquiring blood borne infections by ensuring it had a record of staff members' immunity status.

However we identified areas where the practice did not have systems in place to keep people safe. These included:

- The practice did not have robust arrangements in place to safeguard vulnerable adults and children from abuse. For example, the practice's adult protection policy did not reflect current legislation and local requirements. The policy was not clear and did not assure us that staff would be informed as to what action to take with regard to reporting an incident of abuse. The practice could

not, when requested during the inspection, provide us with a copy of their child protection policy. The practice provided a copy of a child protection policy the week after the inspection. The practice had a lead GP for safeguarding, although not all staff we spoke with were aware who the lead was. The practice did not hold regular child safeguarding meetings to discuss children who might be at risk or on the child protection register. Staff did tell us they might discuss concerns with the health visitor but this would not be recorded. We reviewed the current list of children who were flagged as being at risk on the practice system. This review did not assure us that the practice had oversight of this group of patients and the GP told us that this list had not been reviewed. For example, there were two people who were now in their 20s who were flagged as being at risk children. In addition to this we saw that there had been a recent visit to the practice by a child flagged as being at risk and this had not been appropriately followed up.

- There were limited procedures in place for monitoring and managing risks to patient and staff safety. For example, due to ongoing updates to policies and procedures, the practice did not have an operational health and safety policy. The health and safety policy we reviewed had not been completed or personalised for the practice and did not contain necessary contact details. The practice had undertaken a risk assessment of the premises but this had not been reviewed since December 2013. We saw evidence that a recent audit had been undertaken by NHS property services which identified a number of issues which included that the practice needed fire marshals and that staff needed fire safety training. The practice manager told us they were working to address these issues. We saw evidence that the practice manager conducted daily checks for fire risks and hazards and that regular fire drills were carried out.
- The practice had undertaken no recent risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. The practice building was managed by NHS property services and the practice had obtained a copy of the most recently externally conducted legionella assessment from them. The assessment detailed a large number of actions required to ensure the management and control of legionella but the practice had not managed to seek assurances that these actions had been completed.
- We observed the premises to be generally clean and tidy. Patients told us they found the practice clean and did not have concerns about cleanliness or infection control. However, we found that the practice had not taken reasonable steps to protect staff and patients from the risks of healthcare associated infections. For example, the practice did not have a named infection control lead. Staff we spoke with were not sure who the infection control lead was. The practice manager told us that the lead had been a member of staff who had left but that a new lead had not yet been appointed. The practice had not undertaken an infection control audit since June 2014. The practice policy on infection control had not been updated to reflect current guidance.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

Defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice. All the medicines we checked were in date and fit for use.

The practice did not have a business continuity plan in place for major incidents such as power failure or building damage. The practice manager told us they were working to develop a business continuity plan.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that the practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards. These included National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date through clinical meetings which were held four to six weekly. However, clinical meetings were always held on the same day which meant that some GPs were unable to attend due to this being a non-working day for them. Therefore the practice could not be assured that new information had been fully disseminated to all clinicians. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We reviewed the most recently available published data for the QOF from 2013/14 which showed that the practice had achieved 87.7% of the available points. This represented an improvement on performance from the previous year but was below the CCG average of 92.9% and the national average of 93.5%. Data showed:

- The practice had achieved 75.6% of points available for diabetes related indicators which was below the CCG average of 86.2% and below the national average of 89.2%. This was similar to their performance for the previous year.
- The practice had achieved 96.2% of points available for hypertension related indicators which was slightly below the CCG and national average of 97.8%. The represented an improvement in performance compared with the previous year.
- The practice had achieved 76.9% of points available for dementia related indicators. This was significantly below the CCG average of 91.1% and the national average of 94.5%.

Some clinical audits were carried out within the practice. There had been four clinical audits completed in the last two years, three of these were completed audits where the practice had undertaken re-audit, although changes or improvements had not always been made, implemented or monitored. For example, the practice had undertaken an initial minor surgery audit and a re-audit had been undertaken the following year but no changes or improvements had been made to practice. The audit considered infection and complication rate against a criteria set by the individual GP at complication rate of 10% including infection. The audit did not reference national guidelines. The practice had undertaken an audit on the diagnosis of pulmonary embolism (a blockage in the main artery of the lung) and the use of d-dimer testing (a method of testing to look for blood clotting problems) in the process. We saw that this was a comprehensive audit with a clear and detailed report of findings and evidence of the incorporation of NICE guidelines. This audit led to changes in process and recording to ensure more uniform implementation of NICE guidelines.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. The lead GP was also involved with work at a CCG level and felt that this had benefitted the patients of the practice due to more coordinated working. For example the practice had worked as part of a multidisciplinary team to ensure arrangements were in place to manage the frequent A&E attendances of a patient.

Effective staffing

We found that the practice had made improvements with regards to supporting members of staff:

- The practice had an induction programme for newly appointed members of staff that covered such topics as confidentiality, equipment and systems.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors.
- All staff had had an appraisal within the last 12 months.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding, basic life support and information governance awareness. The practice did not currently use e-learning but were considering investing in this to ensure that they had more effective oversight of training needs.

Coordinating patient care and information sharing

Most of the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system. This included care and risk assessments, care plans, medical records and test results. The GP told us that they did not scan copies of DNACPRs on patient records. (DNACPRs are management plans or orders on records to advise not to attempt resuscitation). The practice explained that, rather than scan the DNACPR, they recorded on the patient record when these were issued and added a date for follow up. The practice told us that DNACPRs were dark red in colour as per the local agreement to make these conspicuous when left in the patient home. The practice told us that scanned copies were illegible on the patient records. The practice additionally expressed concern at taking the completed forms away from the patient home.

We saw that information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. Prior to our inspection in February, multidisciplinary meetings were not formally minuted. We saw evidence that there had been one recorded multidisciplinary meeting in July 2015. This was attended by one GP, practice nursing staff, the district nurse, social worker and administrative staff from the practice. The practice held regular meetings to discuss patients on their palliative care register; however the practice did not use care planning for this group of patients to record information about the patient's wishes including their preferred place of death.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However a GP we spoke with was not aware if they had any patients who were currently subject to Deprivation of Liberty Safeguards (DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom). When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to relevant services to receive assistance. The practice had a range of health promotion and prevention information available in the patient waiting area. For example there was information about memory service support group meeting dates, carers' information and diabetes information.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 71.3%, which was slightly below the CCG average of 76% and the national average of 74.3%. The practice followed up patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice rate of attendance for breast cancer screening was higher than the CCG and national averages.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92.2% to 96.6% and five year olds from 95.2% to 100%. Flu vaccination rates for the over 65s were 76.5%, and at risk groups 60.6%. These were marginally above CCG and national averages.

Requires improvement

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During the inspection we saw that staff were helpful to patients, both at the reception desk and on the telephone. We observed that patients were treated with dignity and respect. Consulting and treatment rooms had curtains provided in order to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. The reception desk was situated around the corner from the waiting area so patients speaking with reception staff could not be overheard.

Fifteen of the 17 completed CQC comment cards we received were wholly positive about the service experienced. Patients said they were pleased with the care and treatment they received and felt that staff were caring and helpful. Patients said they were treated with dignity and respect. We spoke with a member of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors. For example:

- 95% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 95% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 89% 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%.

Patients generally found the receptionists helpful. For example:

- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us they felt involved indecisions about their care and treatment and issues related to their health were discussed with them. Patients said they felt involved in decisions which needed to be made about their care and treatment. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views. Some patients noted that they sometimes had to wait for their appointment but said they knew this was because the GPs would not rush patients.

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

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 88% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room 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. There was a practice register of all people who were carers and were being supported, for example, by

Good

Are services caring?

offering health checks and referrals for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them via telephone or visit. Patients were signposted to local support services.

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 plan services and to improve outcomes for patients in the area. For example, the practice had been involved in discussions to make improvements to its premises.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered late opening until 8.00pm on a Monday evening and early morning opening on a Thursday from 7.30am
- There were longer appointments available for people with a learning disability and the practice had systems in place to ensure patients with a learning disability would not be kept waiting longer than necessary.
- Home visits were available for patients who were housebound or would benefit from these
- Urgent access appointments were available
- There were disabled facilities, hearing loop and translation services available
- Following a suggestion from a patient, the practice had worked with the property services team to ensure improvements were made to its disabled parking area

Access to the service

The practice was open between 8.00am and 6.30pm Tuesday, Wednesday and Friday. The practice opened from 7.30am to 1.00pm on Thursday and from 8.00am to 8.00pm on Mondays. On Tuesday, Wednesday and Friday appointments were available from 8.30am to 5.30pm, excluding between 11.30am and 2.00pm. On Thursdays appointments started at 7.40am and finished at 11.30am. The last appointment on a Monday evening was at 7.40pm. The practice told us that 50% of appointments were pre-bookable up to 14 days in advance with the remainder being available on the day. Same day appointments were available through an advanced nurse practitioner led triage system. The current appointment system had been brought in following suggestions from the practice's PPG. Patients could access appointments with a male or female GP.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 80% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 86% patients said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 73%.
- 68% patients described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%.
- 62% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69% and national average of 65%.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system including leaflets and posters. The practice also had a suggestion box. Patients we spoke with generally said they were not aware of the process to follow if they wished to make a complaint but would feel confident in finding this information should they need it.

The system for logging complaints was not robust and we were not assured that all complaints were being appropriately investigated or responded to. For example, some complaints and their corresponding actions logged in 2015/2016 were not numbered or dated so we could not be sure when these had been received or responded to.

The practice told us they did not undertake any analysis of complaints or significant events on a regular basis to look for themes or trends. This contradicted the practice policy in respect of the management of complaints.

We tracked three complaints received in the last 12 months and reviewed the complaints logs for 2014/15 and 2015/16. We found that written complaints were responded to promptly and compassionately. However, evidence of detailed investigation was limited. We reviewed a verbal

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

complaint and found that this had not been dealt with in line with the practice's complaints procedure. There was no recorded evidence of investigation of the complaint and no evidence to assure that it had been dealt with in a timely manner. In addition to this there was no evidence to suggest that the patient had received a response to their complaint.

Some lessons were identified as a result of complaints but these were not always clearly documented. The practice missed opportunities to recognise some complaints as significant events and learning was not always shared widely enough. For example, one complaint involved two locum GPs but there no evidence that the complaint had been discussed with one of the GPs. Further to this, there was no evidence to assure us that learning which may have been identified from the complaint was fed back to the locums.

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 told us they had a vision to provide the 'right care at the right time by the right person' to its patients. We found this vision and commitment to patients was reflected in our conversations with staff.

Although the practice did not have documented strategy or business plan which reflected their vision and values, there was evidence that they had considered succession planning. The lead GP told us plans included adding a partner to the practice and improving the premises. Staff we spoke with were aware of some plans in place to improve the premises.

Governance arrangements

There was a leadership structure within the practice although the majority of the roles were assumed by the partner and the practice manager. There were a number of areas where this system was leading to gaps in processes and records, exposing patients to potential risk. In spite of areas of weakness identified through the previous inspection these areas had still not been improved as the practice governance systems were not sufficiently robust.

The practice manager and lead GP did not hold any formal meetings to discuss governance and the lead GP had limited oversight of areas such as health and safety.

We identified a number of weakness in the practice structures and procedures:

- Nearly all lead roles were assumed by the lead GP or practice manager with little delegation of responsibility
- Not all staff were aware of who had lead responsibility in which area, for example in relation to safeguarding and infection control
- The practice had a number of policies and procedures in place to govern activity. However, the practice did not have clear system in place for the management of its policies and procedures due, in part, to an ongoing transfer of policies to a new electronic system. This meant the practice had a number of policies which were not fit for purpose as they had not been adapted to be specific for the practice or had not been updated to reflect the most recent guidance. Some policies were available to staff via a shared drive and others were available as hard copies.
- The practice did not always follow its own policies and procedures, for example in relation to the management of complaints and undertaking criminal records checks for all staff.
- The practice had some arrangements for identifying, recording and managing risks; however we did not see evidence of a consistent approach to risk management which ensured patients, staff and others were protected against harm. For example, the practice had not undertaken risk assessments in relation to health and safety since December 2013. The provider could not when requested provide evidence to demonstrate that quality and risk were being discussed in meetings to ensure oversight.
- Although the practice demonstrated the use of clinical audit to improve quality in some areas, their approach to audit needed to be strengthened.
- The practice did not have robust systems in place to manage, assess and monitor children identified as being at risk of harm.
- We were not assured that there were robust arrangements in place to thoroughly investigate and learn from significant events and complaints.

Leadership, openness and transparency

The lead partner and salaried GPs within in the practice demonstrated a breadth of skills. However, we were not assured that there was adequate capacity of leadership available to run the practice in a manner which ensured high quality care. The lead GP was absent from the practice two days per week due their role within the CCG. This meant the practice manager had day to day responsibility for significant areas of the practice. The lead GP and the practice manager did not hold formalised meetings to ensure effective governance and oversight. Areas such as risk and business planning were discussed formally. However, the practice manager had been receiving mentorship from another practice in the area to try to improve systems within the practice. The lead GP told us they encouraged the practice manager to delegate tasks to the assistant practice manager.

Staff told us that the lead GP, the salaried GPs and the practice manager were all approachable and always took the time to listen to staff. Staff told us they felt valued within the practice and that management had an open door policy.

Are services well-led?

Inadequate

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

The practice provided evidence of one team meeting which had been held since the previous inspection in 2014. Staff told us they had the opportunity to raise issues at meetings of this type and felt supported if they did.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had been active in improving patient access through the suggestion of a nurse-led triage system.

The practice had limited mechanisms to formally gather feedback from staff although all staff said that management were approachable and they would feel comfortable giving feedback.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **We found that the registered person had not ensured that checks were undertaken to ensure persons employed were of good character. For example, the provider had not carried out checks with the disclosure and barring service for all members of staff. Further to this the provider had not assessed the risk to service users which resulted from these checks not having been undertaken.** 19 (1) (a)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured they were providing safe care and treatment because risks to the safety of patients and others were not assessed. For example the provider did not have a health and safety policy in place.** **Regulation 12 (2) (b)** **The provider had not taken steps to assess the risk of, prevent and control the spread of infection. For example, the practice did not have an identified lead for infection control.** **Regulation 12 (2) (h)**

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 **Safeguarding service users from abuse and improper treatment** **The provider did not have systems in place to protect service users from abuse and improper treatment.** **For example, records related to children identified as being at risk were not up to date. The provider did not hold regular documented meetings with other professionals to discuss children at risk of harm.** **Regulation 13 (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Enforcement actions

Surgical procedures

Treatment of disease, disorder or injury

The provider did not have effective systems in place to handle complaints.

For example, we reviewed a verbal complaint regarding an allegation of harm. The provider had not considered the complaint as a significant event. The provider could not, when requested, provide any evidence of investigation or response into the complaint.

Regulation 16 (2)