The Stanmore Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection of The Stanmore Surgery on 25 May 2016. The practice was judged to be inadequate and placed in special measures. After this inspection the practice wrote to us to say what action they would take to meet the following legal requirements set out in the Health and Social Care Act (HSCA) 2008:

Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

This announced comprehensive inspection was carried out on the 6 June 2017 to check that action had been taken by the practice to make the improvements required from the inspection in May 2016.

Overall the practice is rated as inadequate from this inspection as it has failed to address a number of issues identified in the previous inspection and further issues were identified.

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. However we found that some incidents that had occurred had not been recorded and investigated as significant events.
- Where an incident had been recorded the practice had not carried out an analysis of the event and recorded learning points that had been identified to show that the practice was fostering a culture of learning and improvement.
- Risks to patients were not assessed and managed.
- Outcomes for patients who use services were not improving, for example latest unpublished QOF data showed the practice was currently achieving only 56% of the overall points available to them.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.

Summary of findings

- We were not assured that there was discussion and leadership around best practice and clinical guidelines at practice level.
- Patients who completed comment cards said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice did not have information on display that informed patients about language interpretation services available.
- The practice had a number of policies and procedures to govern activity, but these were not being followed.
- Though the practice had a leadership structure, there was insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvement are;

- Ensure care and treatment is provided in a safe way to patients.
- Ensure appropriate standards of hygiene for premises and equipment.
- Ensure effective systems and processes to ensure good governance in accordance with the fundamental standards of care

In addition the provider should:

- Develop a system that obtains patients views on improving the service and review areas where the practice have scored below average from the national GP survey results.
- Provide information or notices advising that formal translation services are available for patients who did not have English as a first language who require translation services.

This service was placed in special measures in May 2016. Insufficient improvements have been made such that there remains a rating of inadequate for safe, effective and well led Therefore we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 inadequate for safe services

The practice had not fully taken action to address the areas which required improvement during our previous inspection in May 2016.

- There was no analysis of significant events and any learning points that were being identified to show that the practice was fostering a culture of learning and improvement.
- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example we found concerns with recruitment, infection control, medicine management, anticipating events, management of unforeseen circumstance and dealing with emergencies.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

The practice had not fully taken action to address the areas which required improvement during our previous inspection in May 2016.

- There was no programme of clinical improvement initiatives to improve patient outcomes. We were not assured that there was discussion and leadership around best practice and clinical guidelines at practice level.
- Previous data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below the local clinical Commissioning group (CCG) and national averages. The early indications for the 2017 data showed that the performance was reducing further and the practice could not share with us a plan of action to improve.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement. There was no evidence that the practice was comparing its performance to others; either locally or nationally

Are services caring?

Requires improvement

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

The practice had not fully taken action to address the areas which were identified as requires improvement from our previous Inspection in May 2016.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice lower than average for most aspects of care. Whilst the practice were aware of the poor responses. they did not have a clear plan of action to make improvements.
- Patients that we spoke to on the day of the inspection said they were treated with compassion, dignity and respect and the majority said they were involved in decisions about their care and treatment.
- Staff told us that interpretation services were available for patients who did not have English as a first language. However we saw no information or notices advising that formal translation services were available for patients who did not have English as a first language who required them.

Are services responsive to people's needs?

Requires improvement

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

The practice had not fully taken action to address the areas which were identified as requires improvement from our previous Inspection in May 2016.

- The practice had not reviewed the needs of its local population.
- Patients could get information about how to complain in a format they could understand. However, there was no evidence there was learning from complaints to improve the service to patients .

Are services well-led?

Inadequate

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

The practice had not fully taken action to address the areas which were identified as inadequate from our previous Inspection in May 2016.

- The provider had little understanding of the practice. We were not assured that there was clinical guidance provided to the practice by the principal GP.There was no discussion around best practice and clinical guidelines.
- The practice had now implemented a number of policies and procedures in order to govern activity. However these were still not being followed.
- Though staff told us they were supported by the principal GP; it was not clear that their time at the practice was limited and therefore they were out of touch with what was happening during day-to-day management.

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 is rated as inadequate for the care of older people.

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

• The practice offered proactive, personalised care to meet the needs of the older people in its population.

• The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long term conditions.

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

- Performance for diabetes related indicators was below other practices. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 58% compared to the CCG average of 78% and the national average of 78%. Exception reporting for diabetes was 8% which was below the CCG average of 9% and the national average of 12%.
- Longer appointments and home visits were available when needed.
- Structured annual reviews were not undertaken to check that patients' health and care needs were being met.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for safe, effective, and well led and requires improvement for caring and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

Inadequate

- The practice is rated as inadequate for working age people (including those recently retired and students). The provider was rated as inadequate for safe, effective, and well led and requires improvement for caring and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.
- The practice was not proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group as there was limited access to the practice nurse.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safe, effective, responsive and well led and requires improvement for caring and responsive.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice identified 10 patients with learning disability on the register however, there was no recall system in place, and only one patient had been reviewed.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safe, effective, responsive and well led and requires improvement for caring and responsive.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Performance for mental health related indicators was comparable to other practices. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 30% compared to the CCG average of 91% and the national average of 89%.Exception reporting was 0% which was below the CCG average of 8% and the national average of 13%.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 for the most recent data. The results showed the practice was performing mostly in line with local and national averages. Two hundred and fifty three survey forms were distributed and 99 were returned. This represented 4% of the practice's patient list.

- 76% of patients described the overall experience of this GP practice as good compared with the CCG average of 78.5% and the national average of 85%.
- 61% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 69% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79.5%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 15 comment cards which were all positive about the standard of care received. We spoke with three patients including one members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Ensure appropriate standards of hygiene for premises and equipment.
- Ensure effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Develop a system that obtains patients views on improving the service and review areas where the practice have scored below average from the national GP survey results.
- Provide information or notices advising that formal translation services are available for patients who did not have English as a first language who require translation services.

The Stanmore Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser.

Background to The Stanmore Surgery

Stanmore Surgery is located in Stanmore, Middlesex. The practice provides care to approximately 2300 patients. The practice is registered as a sole provider with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; diagnostic and screening procedures; family planning services and maternity and midwifery services.

The practice has a General Medical Services (GMS) contract and provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning and sexual health services.

The practice is staffed by two part time GPs, one male principal GP and one locum GP who provide a combination of eleven sessions a week. The practice also employs two part-time practice nurses and one healthcare assistant who work a combination of two days a week and a total of nine hours a week. The practice has one part time practice manager working ten hours a week and an assistant practice manager also working ten hours per week. The rest of the practice team consists of three part time administrative staff consisting of medical secretaries and reception staff.

The practice is open between 8am and 6pm on Monday, Tuesday, Thursday and Friday and between 8am and 1pm on Wednesday. Extended hours appointments are offered on Monday between 7am and 8am. Outside of these hours, the answerphone redirects patients to their out of hours provider.

The practice had been previously inspected and areas for improvement were found.

Why we carried out this inspection

We undertook a comprehensive inspection of The Stanmore Surgery on 25 May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe, effective and well led services and was placed into special measures for a period of six months.

We also issued a warning notice to the provider in respect of safe care and treatment and informed them that they must become compliant with the law by 31 August 2016. The full comprehensive report inspection can be found by selecting the 'all reports' link for The Stanmore Surgery on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of The Stanmore Surgery on 6 June 2017. This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice could come out of special measures.

Detailed findings

How we carried out this inspection

Before visiting, 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 visit on 6 June 2017. During our visit we:

- Spoke with a range of staff including the principal GP, practice manager; nurse & administrative staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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).

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.

Inadequate

Are services safe?

Our findings

At our previous inspection on 25 May 2016, we rated the practice as inadequate for providing safe services as the arrangements in reporting incidents, near misses, safeguarding, recruitment, infection control, medicines management and dealing with emergencies were inadequate.

There had been improvements when we undertook a follow up inspection on 6 June 2017 in some areas but largely the practice had not addressed some serious concerns. The practice remains inadequate for providing safe services.

Safe track record and learning

At our previous inspection on 25 May 2016, we found that the practice systems for reporting and recording significant events were inadequate. At this inspection we found that although the practice had implemented a policy on recording significant events their systems were still not adequate.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice had recorded one significant event that had occurred at the practice in July 2016. However there was no analysis of the event and no learning points that had been identified to show that the practice was fostering a culture of learning and improvement. When we spoke with staff at the practice they told us of an incident that occurred at the practice around two weeks prior to our inspection. They explained that an elderly patient had a fallen when walking out of the GPs room downstairs. They explained that they had reported the incident to the provider and recorded it in the incident book. However we saw no evidence that this incident had been recorded as a significant event and no audit trail of the incident being investigated/discussed and learning points being identified.

Overview of safety systems and processes

Our last inspection on 25 May 2016 found that the practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- At this inspection on 6 June 2017 we found that arrangements for safeguarding now reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who was the principal GP. However the principal GP was at the practice for only three sessions per week. We saw no evidence of a system that staff would follow in the absence of the principal GP if they had safeguarding concerns.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training in safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three, nurses to level 2 and non- clinical staff to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice had not maintained appropriate standards of cleanliness and hygiene.

- Our previous inspection on 25 May 2016 had identified concerns with infection control. At this inspection on 6 June 2017 we found no improvements had been made.
- The premises were not cleaned to a satisfactory standard. We observed cobwebs on the wall of the staircase and in the staff toilets. The carpet in the reception area was stained. We saw no record of any arrangements that were in place to ensure the carpet was satisfactorily cleaned. The clinical areas were visibly clean however the flooring was not in line with recommended guidelines and the sinks and taps at the practice were not in line with recommendations.
- We observed that the staff toilet upstairs did not have a sink and the previous inspection had identified

concerns with infection control as staff were washing their hands in the kitchen. We observed a sign outside the toilet advising staff to wash their hands in the store room. However on the day of the inspection we observed that some staff were still washing their hands in the kitchen and the toilet did not have toilet roll. The provider advised they were aware of the building improvement[CB1] work that was required however the current CQC special measures had made it difficult to source for funds and to make the necessary building improvements.

- We looked at the practice infection control policy and procedures. The cleaning schedules detailed duties that were meant to be undertaken daily. We were told by both the receptionist and the practice manager that the cleaner attended twice a week. From looking at the schedules; (only three weeks' worth had been completed - the cleaner attended one day one week, twice another week and as at Tuesday 6 June 2017 for week ending 9 June 2017 – the cleaner had been once). Though the cleaner recorded that they had completed the duties on the days they attended no staff at the practice checked this to ensure the cleaning had been completed to a satisfactory standard.
- We spoke to the nurse regarding the cleaning of medical equipment. They told us that they performed these duties at the end of their shift. They told us that they did not follow a cleaning schedule or policy but relied on their professional assessment to judge what needed to be cleaned.
- The cleaner's cupboard located towards the back of the ground floor area that led to the consultation rooms contained various chemical products. This cupboard did not lock and the handle was at a height that would enable a child to open the door. This presented a potential safety risk as the children could access cleaning materials stored in the cupboard.
- We asked for the practice to show us any infection control audits that had been undertaken. The provider told us that an infection control audit had been undertaken. However we were given an infection control statement that was incomplete instead and advised that the infection control audit was based on the sheet supplied. This annual infection control statement noted that the practice had not had any significant events related to infection control. The statement had a further section that detailed on audits relating to infection control. This stated that an audit had been undertaken between 1 January 2017 and 17 May 2017. However the sections for the findings of the audit were blank.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal) however they were not fully effective.

- At our previous inspection on 25 May 2016 we found concerns with the practice processes for handling repeat prescriptions which included the review of high risk medicines. During this inspection on 6 June 2016 we found improvements had been made with the process. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred.
- Patients on high risk medicines were being followed up.
- The practice carried out medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored. However we found no system that was in place to monitor their use. An administrative member of staff at the practice had developed their own system on monitoring prescription pads. However no one else at the practice was aware of or using the system.
- Emergency medicines were appropriately stored but no record was kept of any checks carried out to ensure that emergency medicines were in date. We found that one emergency medicine in the emergency box, Ventolin Nebules, had expired in August 2016. We asked the practice nurse if the practice had any other supplies of this medicine for use and they told us that none was available. The practice advised us they were going to dispose of the expired medicines.
- We looked at the practice medicines management processes for emergency medicines. We found a monitoring form used to check the stock and expiry dates of emergency medicines but this had not been completed. We asked the practice nurse and practice manager to see copies of the last fully completed sheets but none were available. The practice manager and the

provider both told us that the nursing staff were responsible for checking the emergency medicines and the provider was not aware they were not checking the medicine.

- The practice did not have a system of managing Medicines and Healthcare Regulatory Agency (MHRA) alerts. When we spoke with the practice manager; they told us that no MHRA alerts had been received at the practice since they were in post in January 2017. The practice manager showed us a mailbox on their computer they had set up with the local CCG to ensure the alerts were received at the practice. However the provider reported to be receiving the alerts and printing them and reviewing the action that was required to be undertaken. However we were not shown this file as the provider advised they had given the file to the practice manager but the practice manager was not aware of this.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified[CB2]).
- We reviewed four personnel files and found

Monitoring risks to patients

The inspection on 25 May 2016 found concerns with procedures for assessing, monitoring and managing risks to patient and staff safety. At this inspection we found no improvements had been made and additional concerns were identified.

- A fire risk assessment had been completed by an external company for the practice in March 2016. This assessment was due for review in March 2017. We asked the practice manager if this review had been completed however no documentary evidence was provided.
- The fire risk assessment from March 2016 had a number of actions some of which had been completed including removing flammable materials from above the boiler. The fire risk assessment had recommended that the practice purchase a fire alarm. However this had not been done. The practice manager advised that they had enquired about the cost but that it would be approximately £5000 which was too expensive for the provider; particularly when the practice was in special measures which had created uncertainty about the future.
- The practice were using smoke detectors. The practice manager informed us these were tested to ensure they were working every three to four months however no record of the checks was kept to show that this had been done.
- The fire risk assessment from March 2016 had made the recommendation that fire drills be undertaken at the practice and must be recorded. The practice manager told us that a fire drill had been undertaken in February 2017; though there was no documentary evidence of this and no action points identified.
- The practice had not completed any other risk assessments of the premises. The practice manager said they had completed a general health and safety risk assessment in May 2017. The assessment shown to us on the inspection day was blank.
- We also saw that there was a storage room upstairs full of stacked boxes and various equipment items that would have posed a fire risk or injury to staff. When we addressed this with the practice manager; they told us this had not been their priority since being in post as they were other matters that needed addressing. The risk of this room had therefore not been assessed.
- The inspection team also saw that outside of the premises at the bottom left hand side of the front of the property there were covered cables running into a small box that was uncovered. The box had loose wires sticking out of it. The practice manager told us they were unaware of this but in their opinion it looked like something for a TV aerial.
- We also observed that the carpet in the GP consultation room on the ground floor had come undone at the door. This posed a risk for falls for patients visiting the practice. On the morning of the inspection the inspection team brought this to the attention of the practice managers and the provider. However no action had been taken by the practice to minimize the risk identified by the inspector by the time the inspection team left the practice at the end of the day.

Inadequate

Are services safe?

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements to respond to 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.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. However no checks were being completed to ensure this equipment was in good working order. The provider and the practice manager both told us that the nursing staff were responsible for checking the equipment to ensure it was in good working order. However the monitoring sheets we saw from March 2017 had not been completed.
- All staff received annual basic life support training according to information provided to us. However we asked the practice nurse to show us how she would check that the equipment was in good working order and how the equipment was used. The nurse could not demonstrate this to us. They told us they had received training but were unable to operate the oxygen and the AED.

The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 25 May 2016, we rated the practice as inadequate for providing effective services as the arrangements in respect of patient outcomes were significantly below clinical commissioning group (CCG) and national averages.

Little reference was made to quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.

These arrangements had not improved when we undertook a follow up inspection on 6 June 2017. The provider remains inadequate providing effective services**.**

Effective needs assessment

At our inspection on 25 May 2016 we found that the practice did not have an effective system to keep all staff updated with relevant and current evidence guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. During this inspection on 6 June 2017 we found that, the practice could still not evidence that they had systems in place to keep all clinical staff up to date.

Management, monitoring and improving outcomes for people

The practice could not demonstrate to us how they used Quality Outcomes Framework (QOF) data to gain an understanding of the performance of the practice. (QOF is a system intended to improve the quality of general practice and reward good practice). National data showed the practices overall QOF performance for 2015/16 was significantly below average compared to GP practices within the CCG and nationally (56% compared to 96% and 95% respectively). The practice was aware that their performance had been poor but the early indications for the 2017 data showed that the performance was reducing further. The provider and the practice manager did not have a clear plan of action on how the practice was planning to make improvements and ensure that the performance improved. According to the provider the main solution for them had been to employ a health care assistant to take responsibility for this area of work. This person was only at the practice for three hours per week and had only been employed at the practice for one month. We saw no evidence of the involvement of the provider in undertaking the improvements or a plan of action this person was to follow considering their time at the practice was very limited. The provider was at the practice for three clinical sessions per week.

Our inspection on 25 May 2016 found that the practice achieved poor outcomes in all indicators and performance was worse than local and national average. This data had still not improved at this inspection.

Data from 2015/2016 showed:

- Performance for diabetes related indicators was below other practices. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 58% compared to the CCG average of 78% and the national average of 78%. Exception reporting for diabetes was 8% which was below the CCG average of 9% and the national average of 12%.
- Performance for mental health related indicators was below other practices. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 30% compared to the CCG average of 91% and the national average of 89%.Exception reporting was 0% which was below the CCG average of 8% and the national average of 13%.
- 23% of patients diagnosed with dementia had a face to face review compared to the CCG average of 87% and 84%. The practice had seventeen patients who were eligible for the screening. Exception reporting was 0% which was below the CCG average of 7% and the national average of 7%.

Our inspection of 25 May 2016 found that there was limited evidence of quality improvement activity, which included clinical audit. At this inspection on 6 June 2017 the principal GP produced the same audits from the previous inspection and could therefore not evidence that improvements had been made.

Effective staffing

Our inspection on 25 May 2016 found that there was no formal training or development process in place. At this inspection we found that there had been some improvements.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- The practice were planning to identify the learning needs of staff through a system of appraisal. Most staff at the practice were recently employed and so their appraisals were yet to be completed.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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 and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of two documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. We saw evidence that practice staff were in touch with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation

The practice's uptake for the cervical screening programme was 73%, which was below the CCG average of 77% and the national average of 82%. The practice could not demonstrate there was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given had wide variations to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 33% to 81% and five year olds from 38% to 83%.Both sets of childhood vaccinations were below the 90% national standard.

Our inspection on 25 May 2016 could not demonstrate that patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. At this inspection on 6 June 2017 the practice could still not assure us that patients were being offered these checks.

Requires improvement

Are services caring?

Our findings

At our previous inspection on 25 May 2016, we rated the practice as requires improvement for providing caring services as there was no active website for patients and not all patients felt listened too. At this inspection the practice told us they had a practice website however we could not access it. They explained that the website was accessible via NHS choices but this information was not readily available for patients.

The ratings for providing caring services remain as requires improvement.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 15 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three patients including one members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs but fell below for nurses. For example:

- 95% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 92%
- 93% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 80% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 91%.
- 78% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 92% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 69% of patients said they found the receptionists at the practice helpful compared with the CCG average of 84% and the national average of 87%.

The practice were aware of the areas they required to make improvements in. However they had not yet established the plan of action needed to achieve improvements.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Requires improvement

Are services caring?

Results from the national GP patient survey published July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages for involvement with GPs but below for nurses. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 74% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 90%.
- 74% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice were aware of the areas they required to make improvements in. However they had not yet established the plan of action needed to achieve improvements.

The practice could not fully demonstrate that they provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. However we saw no information or notices advising that formal

  translation services were available for patients who did not have English as a first language who required them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 27 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 25 May 2016, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of recording, investigating and learning from complaints needed improving.

These arrangements had not improved when we undertook a follow up inspection on 6 June 2017. The practice remains rated requires improvement providing responsive services.

Responding to and meeting people's needs

We found no evidence that the practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services.

- The practice offered extended hours on a Monday between 7am and 8am
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice is open between 8am and 6pm on Monday, Tuesday, Thursday and Friday and between 8am and 1pm on Wednesday. Extended hours appointments are offered on Monday between 7am and 8am. Outside of these hours, the answerphone redirects patients to an out of hours provider. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey published July 2016 showed that patient's satisfaction with how they could access care and treatment was mixed compared to local and national averages.

- 60% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 57% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 70% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 70% and the national average of 76%.
- 85% of patients said their last appointment was convenient compared with the CCG average of 87% and the national average of 92%.
- 61% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 30% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 44% and the national average of 58%.

The practice were aware of the areas they required to make improvements in. However they had not yet established the plan of action needed to achieve improvements.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The feedback from patients relating to how they could access care and treatment had reduced in some areas since our last inspection. The practice were aware of this but had not identified how they were going to make improvements.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Listening and learning from concerns and complaints

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. This was included in the practice information leaflet and displayed in the reception area.

We looked at three complaints received in the last 12 months and found these were not satisfactorily handled. For example a complaint was sent to the practice via NHS England about reception staff attitude. The practice manager told us they had not produced a formally documented response to the patient but had instead telephoned them and resolved the issue. We saw no documentation of this call. We saw no evidence of complaints being shared and discussed with the team. Therefore no mechanisms were in place to ensure lessons learnt were shared with all relevant staff.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 25 May 2016, we rated the practice as inadequate for providing well-led services as there was no vision or strategy for the practice, no overarching governance structure and no clear leadership arrangements.

We saw at our inspection on 6 June 2017 that no improvements had been made. The practice remains rated as inadequate.

Vision and strategy

- The practice did not have a vision to deliver high quality care and promote good outcomes for patients.
- No strategy and business plans were in place to reflect the values of the practice and how these were monitored.

Governance arrangements

The practice did not have clear governance arrangements in place. The practice held no clinical governance meetings, and the systems of learning, sharing and making improvements following Significant Events Analyses (SEA) were not effective. We saw no evidence of discussions following an SEA.

• Though the practice had most key policies, we were not assured that these policies were familiar to the leadership of the practice and they were being followed. For example the practice had implemented a recruitment policy. This stated that all staff commencing work at the practice would need to have completed reference checks. We found that the practice were not following this policy and had recently recruited two staff members who were working without references.

• There was no programme of quality improvement monitoring including continuous clinical and internal audit in place to monitor quality and to make improvements. The practice did not use quality assurance for monitoring purposes. There were no formal systems in place to ensure that staff allocated specific roles were carrying them out effectively. The lack of completed cleaning checks, expired emergency medicines and equipment safety checks had not been identified and acted upon as part of an effective system or process established to ensure compliance with the requirements.

- There were no systems in place that ensured risks were assessed and systems put in place to reduce their occurrence.

Leadership and culture

- The principal GP had little understanding of the required performance of the practice. They had other commitments and were only at the practice for limited times to undertake their clinical role. Therefore the principal GP could not provide sufficient managerial oversight and direction. We enquired about the arrangements that were in place to address the previous CQC concerns and how the practice was working to make improvements. The provider told us that the practice had not sought help as the practice had found it difficult to recruit due to the special measures status. The provider told us the practice were starting to address the concerns found at the last inspection in May 2016. However we found no evidence that the provider had sought help from the local Clinical Commissioning Group and there was lack of engagement from the provider with the special measures support he could have received.
- The practice had employed two practice managers to support staff. They both worked part time hours. From our discussions with the provider and the managers it was clear that there were no formal arrangements to ensure there was sufficient managerial oversight and direction. We asked about the arrangements that were in place to ensure management shared information and met to discuss issues arising at the practice as they all worked on different days. We were told that the management team met informally and no meetings were recorded. During the course of the inspection we found ourselves moving between the practice manager and the provider asking for information that should have been easily available for example the MHRA alerts, infection control audits and fire risk assessments. On numerous occasions the principal GP asked us to make our requests to the practice manager and the practice manager then re-directed us to the principal GP as he was the lead person. Although staff were clear that the principal GP was the lead person; we found that the practice was disorganised and there was a lack of clear leadership.
- Our previous inspection of 25 May 2016 had identified that minimal staff meetings were held at the practice.

Are services well-led?

Inadequate

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

During this inspection staff told us that meetings were held at the practice on an ad hock basis due to staff all working on different days. We saw minutes from previous meetings. However as most practice staff worked on a part time basis it was not clear how all practice staff were kept informed of meetings that had been held as staff could not tell us how they accessed the minutes of meetings.

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

- The practice told us they had an active patient participation group that meet on a regular basis and had eight members. However the staff member who chaired the group could not give us examples of changes that had been made as a result of the PPG. We met one member who the practice told us was a PPG member, however they had little understanding of the group.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was no evidence of focus on continuous learning and improvement at all levels within the practice.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe Care and Treatment There were no systems to ensure consistent analysis and learning from of significant events. Medicines were not appropriately monitored. Oxygen and AED were not appropriately monitored. Premises were not cleaned to a satisfactory standard and infection control processes were not being followed. Fire and Risk assessments were not completed and being followed. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (1) Good governance We found that the practice did not have effective system in place to assess, monitor and improve the quality and safety of the services provided. There were deficiencies in the arrangements for SEAs, medicines management, infection control, emergency equipment and medicines management, recruitment procedures, and risk assessments. The practice did not use quality assurance for monitoring purposes.

This section is primarily information for the provider

Enforcement actions

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