SMA Medical Centre

Quality Report

695–697 High Road Leyton
London
E10 6RA
Tel: 020 8539 2078

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires improvement

Are services responsive? – Inadequate

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

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

This inspection was an announced comprehensive inspection at SMA Medical Centre on 9 and 11 January 2018 as part of our inspection programme.

At this inspection we found:

- Processes for sharing learning and outcomes from significant events, patient safety alerts and complaints was not effective.
- The practice did not always act on information received from external agencies such as medicine changes, safeguarding information, referral requests and diagnosis updates.
- Patients' records were not always contemporaneous; we found evidence of missing consultations.
- Exception reporting was above local and national averages.
- Evidence that health care assistants and reception staff were carrying out medicine reviews and annual reviews for patients with long term conditions without being trained to do so.
- Health care assistants administered flu vaccinations without patient specific directions.
- There were ineffective infection control processes.
- Non-clinical staff added new medicines to the patient records without input form a clinician.
- There was no system to ensure that prescriptions were picked up by patients including vulnerable patients and patients experiencing poor mental health.

Summary of findings

- The process for obtaining urgent medical attention for patients who did not have an appointment was not effective.
- Appropriate staff recruitment checks were not always carried out prior to employment or routinely check once employed.
- The practice did not have an effective system to manage and mitigate risks to the premises, staff and patients.
- The practice did not always comply with the duty of candour.
- Clinical equipment had not undergone portable appliance testing or calibration to ensure they were fit for purpose, safe and in good working order.
- Data from the national GP patient survey showed patients rated services and care below the Clinical Commissioning Group and national averages.
- There were no systems to identify and address poor performance.
- Over 1% of patients had been identified as a carer.
- The practice had an active patient participation group.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure all premises and equipment used by the service provider is fit for use

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

- Work to improve patient satisfaction with services provided.

Following the inspection on 9 and 11 January 2018 urgent action was taken to suspend Dr Syed Ali as a registered provider for six months and a caretaking practice was put in place at SMA Medical Centre. Dr Syed Ali subsequently applied to CQC to cancel his registration and this was granted.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

Areas for improvement

Action the service MUST take to improve

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure all premises and equipment used by the service provider is fit for use.

Action the service SHOULD take to improve

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

- Work to improve patient satisfaction with services provided.

SMA Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and a practice nurse specialist adviser.

Background to SMA Medical Centre

SMA Medical Centre is located in a purpose built building on a busy high road in East London, with good transport links, two disabled parking bays for patients in the staff car park and parking available on surrounding roads. The practice is a part of Waltham Forest Clinical Commissioning Group (CCG).

There are approximately 11,000 patients registered at the practice, 60% did not have English as a first language. The practice has a young population, only 6% of patients were aged over 65 years and 28% were aged under 18. Forty eight percent of patients have a long standing health condition, which is similar to the CCG average of 49% and the practice has a lower rate of unemployment 3% compared to the CCG's 7%. The practice is rated as two on the deprivation scale, where a rating of one represents the most deprived and 10 represents the least deprived.

The practice has one male principal GP and a mix of nine male and female locum sessional GPs who carry out a total of 39 sessions per week. There is one female practice nurse who carries out nine sessions per week and a male and female health care assistant (HCA), the practice manager undertakes both practice management and healthcare assistant roles within the practice and 10 reception/ administration staff members.

The practice is an undergraduate training practice and currently has a fifth and sixth year medical student working with them.

The practice operated under a Personal Medical Services (PMS) contract (a locally agreed alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract).

The practice is open Monday to Friday from 8am, phone lines are also answered at this time and appointment times are as follows:

- Monday 9:30am to 12:30pm and 1:30pm to 8pm
- Tuesday 9:30am to 12:50pm and 4:30pm to 8pm
- Wednesday 9:30am to 12:20pm and 4:30pm to 8pm
- Thursday 9:30am to 12:30pm no appointments in the afternoon
- Friday 9:30am to 12:20pm and 4:30pm to 6:50pm

The locally agreed out of hours provider covers calls made to the practice when it is closed and it is part of the local HUB which provides GP and nurse appointments on weekday evenings and weekends when the practice is closed.

SMA Medical Centre operates regulated activities from one location and is registered with the Care Quality Commission to provide treatment of disorder, disease or injury, diagnostic and screening procedures, surgical procedures, maternity and midwifery services and family planning.

Inadequate

Are services safe?

Our findings

We rated the practice as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because:

- The systems to safeguard patients from abuse were not effective.
- The systems to allow the sharing of learning from significant events was not adequate.
- Appropriate staff checks were not always carried out prior to employment.
- Infection control processes were not effective.
- Portable appliance testing and calibration had not been carried out on clinical equipment and there was no system to routinely check that emergency equipment remained in good working order.
- The process for obtaining urgent medical attention for patients who did not have an appointment was not effective.
- There was evidence that the practice did not act on hospital correspondence regarding patient care.
- The medicines management systems were not safe, including the system for prescribing high risk medicines, conducting medication reviews and repeat prescribing.

Safety systems and processes

The practice did not have effective systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. There was an adult and child safeguarding policy both of which were reviewed in December 2016; these were saved on the practices computer system and in paper copy in the reception area. We noted that one reception staff member we spoke with was unaware of how to access this on the computer system.
- The practice manager told us that the practice worked with other agencies to support patients and protect them from neglect and abuse, but we saw that the practice did not act on guidance from external agencies. For example we reviewed the records of a child on the safeguarding register and found there had been correspondence from an external agency giving the practice advice on how best to communicate with this patient, however we saw there was nothing on the computer system to highlight that this method of communication should be used and there was no evidence this information had been discussed with relevant staff members.
- The practice did not always carry out appropriate staff checks, including checks of professional registration upon recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were not undertaken for all staff members. (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). We found that three reception staff members who we were told did not have chaperoning responsibilities did not have a DBS check. We saw letters that were sent to them stating they did not need one as they would not be alone with patients, but the practice did not complete any risk assessments to support this and there was no lone working policy to provide assurance that these staff members would not be left alone with vulnerable patients. We looked at a random sample of personnel files and found one receptionist had two personal references both given by members of the same household and no professional reference. The practice could not provide us with evidence they had assurance that any of the GPs were on the national performers list; they had no assurance that the practice nurse had indemnity cover and the most recent locum used by the practice only had one reference on file and no pictorial form of identification (only a birth certificate).
- All non-clinical staff received up-to-date safeguarding and safety training appropriate to their role, but we found no evidence of child safeguarding or vulnerable adults training for two GPs, this was however provided post inspection. Staff we spoke with told us they would report any concerns to a GP. Six out of seven staff members who acted as chaperones were trained for the role and had a DBS check.
- The system to manage infection prevention and control was not effective. The practice commissioned an external infection control audit in October 2017; we saw

that the practice had not carried out all actions identified in the report. For example the report stated that the practice should ensure the two vaccine fridges were calibrated and serviced; this had not been done. The practice had two fridges used to store vaccines, one large fridge in the nurse's room, which was over stocked not allowing for the required circulation of air to maintain vaccine temperatures as required by the manufacturers, and a smaller fridge in the room used to carry out minor operations. We saw a note on the small fridge stating that specimens should be stored on the top shelf only, we discussed this with the practice nurse who told us that specimens received or taken by the practice after the daily specimen courier pick up had taken place were stored in the smaller fridge overnight, we noted that this fridge contained over 100 vaccines and there was no separate fridge in the practice to store specimens.

- There were two systems for receiving clinical specimens, one involved patients handing specimens into the reception area and the other was for patients to put their specimen in a double sided cupboard in the patient toilet which could also be opened from a clinical room. There was no lock on this cupboard and it was low enough for a child to gain access. We saw a bag with three urine samples which were not dated in this cupboard; there were also plastic containers and a jug for patients to transfer their sample into the required bottles. There was no policy for the sterilisation or cleaning of these containers to avoid cross contamination and no process to ensure that these samples were collected at the end of day by staff members.
- The practice could not effectively demonstrate that it ensuredfacilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. Portable appliance testing (PAT) had been carried out recently, but we found discrepancies. For example the report stated that 20 computers had been tested but we were told that there were only 16 computers in the practice, the report also stated that there were 20 printers in the practice and there was no PAT testing of clinical equipment. There were systems for safely managing healthcare waste. The practice did not carry out calibration of their clinical equipment to ensure they were functioning effectively.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were not effective.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- We viewed two out of 10 reception staff members' files and found that for both members a staff induction had not been completed. There was also no induction process for clinical and temporary staff members.
- Staff members we spoke with told us that in the case of an emergency on the premises they would speak with the GP or practice manager.
- Reception staff knew how to recognise those in need of urgent medical attention, but the process for them attaining that attention was not effective. For example we were told by receptionists that for one GP when they were on call and had to deal with all urgent patients they would not physically see them if they attended the practice or take any telephone calls. Messages would be passed from the receptionist to the GP who would advise the receptionist of what advice to give or would give them a prescription to give the patient. We saw an example of this for a patient who had not had an asthma review in the last three years and was being over prescribed steroid inhalers. They called the practice as they were having an acute exacerbation of asthma. The GP told the reception staff memberwhat advice to give the patient and this advice was left on the patients' answering machine and was not followed up by the practice.
- Clinicians told usthey knew how to identify and manage patients with severe infections, for example sepsis; however they were unable to provide us with any examples of when they had done this.
- When there were changes to services or staff the practice did not assess or monitor the impact on safety, for example changes to the appointment system.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not always written and managed in a way that kept patients safe. For example, we reviewed the appointment book and found no

record of a consultation for a patient who attended a GP appointment. The care records we saw showed that information needed to deliver safe care and treatment was not always available to relevant staff in an accessible way.

- The practice systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment was not effective. There were no regular documented practice or clinical meetings and we found evidence of other agencies requesting information from the practice which the practice did not share.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice systems for appropriate and safe handling of medicines did not promote safety.

- The systems for managing medicines, including vaccines, and emergency medicines and equipment were not effective. We foundurine and stool specimens were stored in the same fridge as vaccines and there was no system for the routine checking of emergency equipment such as the defibrillator and oxygen to ensure they remained in good working order.
- We found evidence that six patients were being prescribed a fixed dose of the high risk medicine warfarin, which was not adjusted following the required blood test as advised by NICE guidelines. In some cases there was no evidence of the blood tests ever having been completed and some dated back to 2016. We also saw correspondence from a hospital advising that they were not monitoring patients' bloods and also a patient had not been attending their appointments and they requested further information, which the practice did not act upon. We also saw that four patients being prescribed methotrexate were also not monitored adequately.
- The repeat prescribing process was not effective. We found 78 prescriptions dated from October 2017 or older in the prescription box which had not been collected by patients and there was no system to review these. Fifty six of these prescriptions indicated that a medication review was required, one dated back to August 2012. We also noted that there were several of these prescriptions with notes written on them by the GPs to the patients advising them that they needed to book an appointment.
- Staff did not always prescribe or administer medicines to patients and give advice on medicines in line with legal requirements and current national guidance. For example we found one patient being prescribed two medicines over a five year period for a condition which hospital documentation stated the patient did not have. We saw numerous patient records with the entry 'medication review done' by non-clinical staff members and the health care assistant, we also saw that non clinical staff members added new medicines into the patient record; this included an example of a wrong dosage added that was issued to the patient. The health care assistants administered the flu vaccine to patients without patient specific directions (PSD). PSDs are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- The practice had audited antimicrobial prescribing. There was evidence of a reduction in inappropriate antibiotic prescribing, but the practice could not demonstrate how learning from the audits was shared with all relevant staff members.
- Patients' health was not effectively monitored to ensure medicines were being used safely and followed up on appropriately. For example we saw evidence that the practice ignored hospital correspondence advisingmedicine dosages should be reduced. The practice did not always involve patients in regular reviews of their medicines.

Track record on safety

The practice did not have a good safety record.

- The practice was unable to provide us with evidence that they carried out comprehensive risk assessments in relation to safety issues.
- The practice had no systems for monitoring and reviewing activity to understand risks and give a clear, accurate and current picture to aide safety improvements.

Inadequate

Are services safe?

Lessons learned and improvements made

The practice did not effectively learn and make improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The systems for reviewing and investigating when things went wrong were not adequate. The practice did not effectively learn or share lessons, there were no processes to identify themes and they could not always demonstrate that action was taken to improve safety in the practice. We viewed the six significant events logged in the last 12 months and found that learning was only shared and discussed once annually in a review meeting. For example we saw a significant event from July 2017 regarding the incorrect labelling of cervical cytology samples which meant that the samples would have to be repeated, we saw that this was discussed in the annual review meeting four months later. The practice provided us with evidence that they completed a search and identified which patients were required to repeat the sample; however they were unable to evidence that they had contacted these patients and informed them of the error and the need for the screening process to be completed again.
- The system for receiving and acting on safety alerts was not effective as we saw evidence that the alerts were only shared with the GPs who were in the practice on the day the alert was received, the practice nurse did not receive any alert information and these were not discussed at practice meetings.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

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

The practice was rated as inadequate because:

- There were ineffective processes for keeping clinicians up to date with current evidence based guidelines.
- Patient reviews including reviews of medicines, long term conditions and care plans were carried out without a patient consultation.
- Patient reviews including reviews of medicines, long term conditions and care plans were carried out by staff members who were not trained for the role.
- There was no effective management oversight of staff training.
- Not all staff members had received a recent appraisal and not all staff had completed an induction.
- The practice did not always act on information from other organisations and health professionals regarding patient care.

Effective needs assessment, care and treatment

The systems to keep clinicians up to date with current evidence-based practice was not effective. We saw that clinicians did not always assess needs and deliver care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were not always fully assessed. This included their clinical needs and their mental and physical wellbeing. For example we saw numerous medicines reviews carried out without evidence of any discussion with patients and records of long term condition reviews being completed with no detail of any discussions, results or findings in the records.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice could not demonstrate that staff always advised patients what to do if their condition got worse and where to seek further help and support.

The provider was rated as inadequate for being safe, effective, responsive and well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients in all population groups.

Older people:

- The practice did not have a register of older patients who were frail and therefore reviews of these patients to assess their physical, mental and social needs were not carried out.
- There was no system to routinely invite patients aged over 75 for a health check and the practice was unable to tell us how many of these checks had been carried out over a 12 month period.
- The practice did not have a system for following up on older patients discharged from hospital and ensuring that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Annual reviews for patients with long-term conditions were not always carried out by clinicians who were adequately trained for the role.
- For patients with the most complex needs, the GP did not effectively work with other health and care professionals to deliver a coordinated package of care.
- Ninety one percent of patients on the diabetes register had an IFCC HbA1c of 64mmol/mol or less in the preceding 12 months compared to the CCG average of 74% and the national average of 79%. There was an exception reporting rate of 40% compared to the national average of 13%.
- Eighty nine percent of patients on the diabetes register had a blood pressure reading (measured in the preceding 12 months) of 140/80 mmHg or less compared to the CCG average of 79% and the national average of 78%. There was an exception reporting rate of 16% compared to the CCG average of 8% and the national average of 9%.

Families, children and young people:

Inadequate

Are services effective?

(for example, treatment is effective)

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above and ranged from 88% to 100%.
- The practice did not have arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 63%, which was below the 80% coverage target for the national screening programme. There was an exception reporting rate of 18% compared to the CCG average of 9% and the national average of 7%. The practice was aware of its low cytology screening uptake and told us that as a result they put together a dedicated cytology team who improved the recall process. They also informed us that they were now achieving over 80% uptake but were unable to provide us with any data to support this.
- The practice could not evidence that they had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to health assessments and checks including NHS checks for patients aged 40-74.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable; however there was no shared learning and multidisciplinary meetings where these patients were discussed.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. However there was no effective alerting system to highlight who these patients were when they contacted the practice to ensure they received access to priority appointments.

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

- 91% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average of 84%. There was an exception reporting rate of 4%, which was the same as the CCG average and comparable to the national average of 7%. However on review of a sample of patient records we found evidence that reviews were not always done face to face.
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is the same as the national average. There was 0% exception reporting rate, which was below the national average of 13%. However on review of patient records we found no documented care plans available.

Monitoring care and treatment

The practice had a programme of quality improvement activity but did not routinely review the effectiveness and appropriateness of the care provided as a result. The practice carried out four clinical audits in the last two years, one of which was a completed audit cycle about the appropriateness of antibiotic prescribing. The practice completed a single cycle audit looking at flu vaccination uptake in patients aged 65 and over. The audit found that during the given time period 226 patients aged over 65 attended the practice, 205 of whom received the flu vaccine, 12 declined and 9 patients were not offered the vaccine. The audit concluded that 91% of patients aged over 65 received the flu vaccine, which was above the practice target of 75%. The audit stated that posters promoting the uptake of the flu vaccine would be displayed around the practice. There was no evidence that the findings of this audit was shared with all relevant staff members.

The practice took part in a local resilience support initiative and worked with an external agency to look at the overall performance of the practice and any blockers or hindrances in the practice that would affect the practice making progress or improvements.

The most recent published Quality Outcome Framework (QOF) results were 100% of the total number of points available compared with the clinical commissioning group (CCG) and the national average of 95%. The overall exception reporting rate was 17% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good

practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- Exception reporting rates for diabetes related indicators was 22%, which was above the CCG and national averages. For example 20% of patients on the diabetes register whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was excluded compared to the CCG average of 11% and the national average of 13%. The practice also had a 49% exception reporting rate for patients in whom the last IFCC-HbA1c was 59 mmol/mol or less in the preceding 12 months, which was above the national average of 12%.
- The practice was aware of its high exception reporting rate and as a result all exception reporting codes were deleted from patients records, this was discussed in a meeting, however the practice was unable to demonstrate that it shared learning and any changes in processes with all staff members involved in QOF and exception reporting and there were no new documented processes made as a result.
- We saw numerous examples of diabetes, asthma and rheumatoid arthritis annual reviews being carried out by staff members who were not trained for the role, this included medicine reviews and the addition of care plans.

Effective staffing

Not all staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme. We saw that there was a 5% inadequate cervical screening rate, this was not discussed with the sample taker and there was no additional support, training or supervision put in place as a result.

- The practice manager did not demonstrate a sound understanding of the learning needs of staff. Although staff members were provided with protected learning time to carry out training, there was no effective management oversight. Up to date records of staff training was not always maintained and although we were provided with evidence of training post inspection, on the day of inspection the practice was unable to provide us with assurance that all clinical staff members had completed child and adult safeguarding training.
- The practice did not effectively provide staff with ongoing support. There was an induction process but this was not completed by all staff members and there was no induction process for clinical staff members. There was no evidence of one-to-one meetings and not all staff members had a record of an appraisal in the last 12 months. Health care assistants completed the care certificate via online training.
- The practice did not ensure the competence of staff employed in advanced roles and did not monitor their clinical decision making, including non-medical prescribing.
- There were limited systems for supporting and managing staff when their performance was poor.

Coordinating care and treatment

Staff did not work together and with other health and social care professionals effectively to deliver care and treatment.

- We saw records that showed that not all appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. For example we saw a request from a district nurse for a patient to be referred to an insulin clinic due to an extremely high HbA1c result, this was not actioned by the practice and the patient was not reviewed at the in-house diabetic clinic. We also viewed a record of a patient with an elevated HbA1c whose notes stated that a referral to the in-house diabetic clinic was needed, but the referral was never completed and a review of the patient was not carried out.
- Patients did not always receive coordinated and person-centred care, including when they moved between services, when they were referred, or after they were discharged from hospital. The practice did not always work with patients to develop personal care plans, these were not always comprehensive, were not always saved on the practices computer system and was not always shared with patients and relevant agencies.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice sometimes ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff did not effectively help patients to live healthier lives.

- The practice did not proactively identify patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives and patients at risk of developing a long-term condition.
- Staff told us that they encouraged and supported patients to be involved in monitoring and managing their health.
- Staff did not always discuss changes to care or treatment with patients and their carers as necessary. We saw evidence of health reviews, care plans and medication updates being entered on the clinical system without a patient consultation.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- We saw evidence that consent was used appropriately but this was not monitored.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for caring.

The practice was rated as requires improvement for caring because:

- The practice had not carried out any action to improve patient satisfaction as identified from the results of the national GP patient survey.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients support and information.
- 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.
- We received 33 patient Care Quality Commission comment cards, three of which were completed by staff members and 14 patient letters all of which was positive about the care received. This was in line with the results from the NHS Friends and Family Test but not the national GP patient survey.

Results from the July 2017 annual national GP patient survey showed patients did not always feel they were treated with compassion, dignity and respect. Three hundred and eighty seven surveys were sent out and 92 were returned. This represented about 1% of the practice population. The practice was below average for most of its satisfaction scores on consultations with GPs and nurses. For example:

- 74% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 72% of patients who responded said the GP gave them enough time; CCG - 81%; national average - 86%.
- 88% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 92%; national average - 95%.
- 71% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 80%; national average - 86%.
- 84% of patients who responded said the nurse was good at listening to them; (CCG) - 87%; national average - 91%.
- 80% of patients who responded said the nurse gave them enough time; CCG - 86%; national average - 92%.
- 95% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 94%; national average - 97%.
- 77% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 84%; national average - 91%.
- 74% of patients who responded said they found the receptionists at the practice helpful; CCG - 84%; national average - 87%.

The practice was aware of its patient satisfaction scores and told us it was not a true reflection of the care and services provided. We were told that the survey results were discussed with all staff members and the patient participation group (PPG) but the practice was unable to provide us with any evidence of this including any action that was taken as a result to improve patient satisfaction.

Involvement in decisions about care and treatment

The GP patient survey indicated that staff did not always appropriately help patients be involved in decisions about their care. The practice complied with the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English providing patients of services that were available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, we saw staff members use leaflets with maps to explain directions to other services.

Requires improvement

Are services caring?

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers as a part of the registration process and also as part of consultations where this was indicated. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 174 patients as carers (1.6% of the practice list).

- We were told that carers' were offered an annual flu vaccination and were given advice on services and support available to them.
- Staff told us that if families had experienced bereavement, the GP contacted them and offered a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients did not respond 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:

- 75% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 81% and the national average of 86%.
- 60% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 75%; national average - 82%.
- 83% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 85%; national average - 90%.
- 72% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG – 79%; national average - 85%.

The practice was aware of their low patient satisfaction results but could not demonstrate that they carried out any actions to improve this.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, inadequate for providing responsive services across all population groups.

The practice was rated as inadequate for providing responsive services because:

- The practice had not taken action to improve the low GP patient satisfaction scores.
- Patients did not always receive appropriate or timely access to care and treatment.
- Learning and outcomes from complaints were not shared with staff in a timely way.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice had an understanding of the needs of its population and tailored some of its' services in response to those needs. (For example extended opening hours and online services such as repeat prescription requests).
- The practice did not always improve services where possible in response to unmet needs for example the urgent appointment system.
- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was not always effectively coordinated with other services.

The provider was rated as inadequate for being safe, effective, responsive and well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients in all population groups.

Older people:

- The practice did not have a frailty register.
- All patients had the same named GP and they were supported them in whatever setting they lived, whether it was at home or in a supported living scheme.
- Older patients were offered home visits and urgent appointments. The GP accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- The system to provide patients with a long-term condition an annual review to check their health and medicines needs were being appropriately met was not effective and multiple conditions were not reviewed at one appointment.
- The practice held meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues; however actions identified were not always carried out.

Families, children and young people:

- We found there were no systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Parents or guardians calling with concerns about a child under the age of 18 were not consistently offered a same day appointment when necessary.

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

- The practice offered extended opening hours and online services for appointment booking and prescription requests.
- Telephone consultations were available on request which supported patients who were unable to attend the practice during normal working hours.
- There was no practice website here patients could access information without attending the practice.

People whose circumstances make them vulnerable:

- The practice did not maintain a comprehensive vulnerable adults register and there was no system to highlight these patients on the clinical system.

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- Not all staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice offered these patients an annual review of their health, however these appointments were not always carried out by a qualified member of staff and these appointments were not always carried out face to face. There was no system to follow up patients who failed to attend their appointments.

Timely access to the service

Patients were not always able to access appropriate care and treatment from the practice within an acceptable timescale for their needs.

- Patients did not always have timely or appropriate access to initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs did not always receive priority access to care and treatment or direct access to a clinician.
- Waiting times, delays and cancellations were minimal.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages. This was supported by observations on the day of inspection where we saw several patients being directed to other services as there were no appointments available. Three hundred and eighty seven surveys were sent out and 92 were returned. This represented about 1% of the practice population.

- 65% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%.
- 47% of patients who responded said they could get through easily to the practice by phone; CCG – 59%; national average - 71%.
- 67% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 78%; national average - 84%.
- 68% of patients who responded said their last appointment was convenient; CCG - 73%; national average - 81%.
- 58% of patients who responded described their experience of making an appointment as good; CCG - 66%; national average - 73%.
- 24% of patients who responded said they don't normally have to wait too long to be seen; CCG - 47%; national average - 58%.

The practice was aware of their low patient satisfaction scores but no action had been taken to address them.

Listening and learning from concerns and complaints

The practice management team told us they took complaints and concerns seriously and responded to them appropriately to improve the quality of care; however we saw evidence that did not support this.

- Information about how to make a complaint or raise concerns was available and it was easy to do.
- The practice did not always maintain records of verbal complaints.
- The complaint policy and procedures were in line with recognised guidance. Five complaints were received in the last year. We reviewed all five complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints; however learning and outcomes were not shared with relevant staff members in a timely way. For example, we saw a complaint from a patient about inappropriate treatment and learning and outcomes from this was not discussed with practice staff until four months after the incident during the annual review meeting, where all complaints for the year were discussed for the first time.

Are services well-led?

Inadequate

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

Our findings

We rated the practice, and all of the population groups as inadequate for providing a well-led service.

The practice was rated as inadequate for well-led because:

- There was no credible practice strategy in place.
- Practice policies and procedures were not always adhered to.
- The processes for sharing learning within the practice was not effective.
- Insufficient detail was given to identifying and managing risks within the practice.
- There were no processes for ensuring that clinicians had the right skills and competencies to carry out their role.

Leadership capacity and capability

Leaders did not demonstrate that they had the capacity and skills to deliver high-quality, sustainable care.

- Leaders did not have the capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges but were not effective in addressing them.
- Leaders at all levels were visible; however we were told they were not always approachable. They did not work closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice did not have processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a vision but no credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a vision but the practice values did not support this. The practice had no clear strategy and told us they were working on business plans to achieve priorities.
- The practice planned its services to meet the needs of the practice population.

Culture

The practice did not demonstrate a culture of high-quality sustainable care.

- Not all staff stated they felt respected, supported and valued or proud to work in the practice.
- The practice told us they focused on the needs of patients, but this was not always corroborated by evidence.
- There was no clear system for leaders and managers to act on behaviour and performance inconsistent with the vision and values.
- The practice was unable to provide us with documentation to evidence that openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example we saw that patients were not contacted when there had been medicine errors or when cytology samples needed to be repeated due to a practice error. The provider was aware of but did not have systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns but not all staff felt encouraged or comfortable to do so. They did not have confidence that these would be addressed and we were given examples of this.
- The processes for providing all staff with the development they needed was not effective. This included access to the appropriate training for health care assistants to carry out reviews of some long term conditions and career development conversations. Not all staff had received annual appraisals in the last year.
- Not all clinical staff felt considered as valued members of the practice team.
- Staff were given protected time to carry out mandatory training and updates.
- The practice had not considered ways to actively promoted equality and diversity. Some staff had received equality and diversity training.
- Not all relationships between staff in the practice were positive.

Governance arrangements

Are services well-led?

Inadequate

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

Responsibilities, roles and systems of accountability to support good governance and management were not always clear.

- Structures, processes and systems to support good governance and management were not clearly set out, understood and effective. The governance and management of clinical work, joint working arrangements and shared services did not always promote interactive and co-ordinated person-centred care.
- Staff were not all clear on their roles and accountabilities including in respect of infection prevention and control.
- Practice leaders had established some policies, procedures and activities to ensure safety and assured themselves that they were operating as intended; however we saw that these were not always adhered to. For example the repeat prescribing policy.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not always clear or effective.

- There were ineffective processes to identify, understand, monitor and address current and future risks including risks to patient safety. For example clinical equipment had not been calibrated to ensure they were fit for purpose and in good working order.
- The processes to manage current and future performance was not effective. Performance of employed clinical staff including consultations, prescribing and referral decisions was not monitored.
- Practice leaders had oversight of MHRA alerts, incidents, and complaints; however learning and outcomes from these were not always shared with all relevant staff members and when it was, this was not done in a timely way.
- Clinical audits were carried out but these were not routinely reviewed to establish their effectiveness or appropriateness, therefore there was not always clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice had plans for service developments and efficiency changes to impact on the quality of care, but this had not yet been completed.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

- Quality and sustainability was not discussed in relevant meetings where all staff had sufficient access to information.
- There were no systems to use performance information to monitor and manage staff and hold them to account.
- The information used to monitor performance and deliver quality care was not always accurate and useful. We found that some clinical records were not contemporaneous and did not always contain sufficient information and information received from other agencies were not always acknowledged and acted upon.
- The practice did not optimise the use of information technology systems to monitor and improve the quality of care.
- The practice did not always submit data or notifications to external organisations as required. For example to specialist nurses when requiring information on shared care patients.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients and external partners to support sustainable services, but they were unable to demonstrate the outcomes from this.

- There was a patient participation group (PPG); the practice was unable to evidence changes that had been made as a result of their suggestions. The PPG with the permission of the practice carried out a reception observation exercise, however there were no outcomes or action plan by the practice as a result of this.

Are services well-led?

Inadequate

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

- The practice was a part of a resilience programme to identify areas where the practice could improve, however this had not been completed.
- When asked, staff were unable to give examples of discussions and suggestions made that led to any service changes.
- The practice told us they were transparent, collaborative and open with stakeholders about performance. We saw that data was shared by the practice with the CCG.