Chessel Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This inspection was an announced focused inspection carried out on Tuesday 20 June 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 27 October 2016. This report covers our findings in relation to those requirements.

This practice has a branch practice at 4 Chessel Avenue, Bitterne, Hampshire, SO19 4AA. During this inspection we did not visit the branch practice.

The full comprehensive report on the October 2016 inspection can be found by selecting the 'all reports' link for Chessel Practice on our website at www.cqc.org.uk.

Overall the practice was rated as requires improvement following the October 2016 inspection. The practice was rated as follows Safe: Good, Effective: Requires Improvement, Caring: Good, Responsive: Requires Improvement, Well Led: Requires Improvement.

Our key findings at the 20 June inspection were:

- The practice was able to provide written evidence that all staff had now received an appraisal. The practice now had a process in place to identify when the next staff appraisals were due.
- The practice had reviewed and was working to improve the number and frequency of patient appointments. The telephone system was being monitored to increase the number of appointment calls and new reception staff were being employed and longer appointments, urgent appointments and home visits were available for patients when needed.

There was no one who had oversight of clinical performance and activity to maintain, and where needed, improve care and treatment. Although we were told at the time of this inspection that a GP from the other practice was always available to assist with clinical leadership.

- Learning from significant events was not always shared with all staff as relevant and recorded. Meeting minutes were not recorded with details of local reviews of significant events.
- Medication audits were not always followed up and actions completed to ensure patients were kept safe.

Summary of findings

The areas where the provider must make improvements 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.

The areas where the provider should make improvements are:

- Review the way significant events are recorded and shared with all staff.
- Review how the practice can improve the quality and effectiveness of clinical care to patients such as the measures found within the quality outcome framework (QOF).
- Complete all recommendations made in the legionella risk assessment.

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

Special measures will give patients who use the practice the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as Inadequate for providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients who used services were assessed; the systems and processes to address these risks were now implemented but not completed, for example the legionella recommendations in the risk assessment had not been completed. The practice was still working through recommendations made in a Legionella assessment and had not completed them since our last inspection.
- Lessons were not always completely shared to make sure action was taken to improve safety in the practice.
- Meeting minutes were not recorded with details of local reviews of significant events.
- Medication audits were not always followed up and necessary actions completed to ensure patients were kept safe, for example a Lithium audit of patients showed that not all patients' had their blood tests completed at the required three monthly intervals.

Are services effective?

Requires improvement

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

- All staff had now received a staff appraisal.
- The practice identified patients who may be in need of extra support and signposted those to relevant services. For example: the practice had a visiting advanced nurse practitioner who visited patients in their own homes.
- The practice gave us unverified Quality and Outcomes Framework (QOF) figures for 2016-2017 which showed that the practice had achieved 86% of the total number of points available.
- The practice was working to increase this figure, but GPs we spoke with did not have knowledge of how the practice was performing with regards to QOF.
- There was no identified lead for QOF outcomes, or other quality improvements. This meant that there was no leadership to drive improvements in relation to performance on QOF, or quality improvements.

Summary of findings

Are services caring?

Good 

The practice is rated as good for providing caring services.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement 

The practice is now rated as requires Improvement providing responsive services.

- Results collected between January and March 2017 from the national GP patient survey in July 2017 showed that patient's satisfaction with how they could access care and treatment was below national averages.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- Urgent appointments were usually available on the day they were requested.
- We were told by staff and patients and patient participation group that the telephone system and being able to get through to the practice was improving.

Are services well-led?

Inadequate 

The practice is rated as Inadequate for being well-led.

The practice had a vision and a strategy. However, some staff we spoke with were not sure of the mission statement and were unsure what responsibilities the GPs had and who to go to with concerns.

- The practice had a number of policies and procedures to govern activity; these were being reviewed and updated to reflect the vision and strategy.
- All staff had received inductions and all staff had received performance reviews.
- Leaders were out of touch with what was happening during day-to-day services. There was a lack of clarity about authority to make decisions.

Summary of findings

- We were unable to check that leaders had the necessary experience, knowledge, capacity or capability to lead effectively.
- The arrangements for governance and performance management did not always operate effectively. There had been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance.

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 overall as inadequate for the care of older people.

The provider is rated as good for providing caring services. Requires improvement for effective services and responsive services. Inadequate for safe and well led services. The issues identified as inadequate overall affected all patients including this population group.

- Longer appointments, urgent appointments and home visits were available for older patients when needed, and this was acknowledged positively in feedback from patients. The leadership of the practice had started to engage with this patient group to look at further options to improve services for them.
- The practice had started to offer proactive, personalised care to meet the needs of the older patients in its population by the introduction of a visiting advanced nurse practitioner who triaged home visits with the assistance of a GP to ensure that decisions were within their competencies.

People with long term conditions

Inadequate

The practice is rated overall as Inadequate for the care of people with long-term conditions.

The provider is rated as good for providing caring services. Requires improvement for effective services and responsive services. Inadequate for safe and well led services. The issues identified as inadequate overall affected all patients including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- The practice ensured all patients had a named GP, those requiring it had a personalised care plan or structured annual review to check that their health and care needs were being met.
- Performance data, supplied by the practice, for learning disability related indicators was 100% of the total number of points available.

Summary of findings

- Performance data, supplied by the practice, for dementia related indicators was 100% of the total number of points available.
- Performance data, supplied by the practice, for diabetes related indicators was 63% of the total number of points available.
- Performance data, supplied by the practice, for mental health related indicators was 77% of the total number of points available.

Families, children and young people

Inadequate

The practice is rated overall as inadequate for the care of families, children and young people.

The provider is rated as good for providing caring services. Requires improvement for effective services and responsive services. Inadequate for safe and well led services. The issues identified as inadequate overall affected all patients including this population group.

- There were systems in place 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 A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this.
- Appointments were available outside of school hours.
- Pregnant women had antenatal appointments with a GP; the practice also hosted a weekly midwife clinic.
- Safeguarding training for staff was up to date and an on-going priority area for the practice.
- The practice's uptake for the cervical screening programme was 95%, which was above national average of 82%.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as overall inadequate for the care of working-age people (including those recently retired and students).

The provider is rated as good for providing caring services. Requires improvement for effective services and responsive services. Inadequate for safe and well led services. The issues identified as inadequate overall affected all patients including this population group. .

Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as overall inadequate for the care of people whose circumstances may make them vulnerable.

The provider is rated as good for providing caring services. Requires improvement for effective services and responsive services. Inadequate for safe and well led services. The issues identified as inadequate overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had carried out annual health checks for patients with a learning disability.
- The practice worked with multi-disciplinary teams in the case management of vulnerable patients.
- The practice had told vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children.
- Staff 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated overall as inadequate for the care of people experiencing poor mental health (including people with dementia).

The provider is rated as good for providing caring services. Requires improvement for effective services and responsive services. Inadequate for safe and well led services. The issues identified as inadequate overall affected all patients including this population group.

- The practice carried out advance care planning for patients with dementia.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had understanding of how to support patients with mental health needs and dementia. Staff had received relevant Mental Capacity Act 2005 training.

Summary of findings

What people who use the service say

The national GP patient survey results from January to March 2017, were published in July 2017 and showed the practice was performing below local and national averages, 231 survey forms were distributed and 98 were returned. This represented about 0.8% of the practice's patient list.

- 17% found it easy to get through to this surgery by phone compared to a national average of 73%.
- 57% were able to get an appointment to see or speak to someone the last time they tried compared to a national average of 77%.
- 49% described the overall experience of their GP surgery as fairly good or very good compared to a national average of 86%.
- 29% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to a national average of 80%.

We spoke with two patients who both told us that the level of care and GPs working at the practice was very good. They felt the practice was improving as more regular GPs worked there.

Friends and family survey responses for April, May and June 2017 showed that more patients would recommend the practice rising from 57% in April 2017 to 68% in May 2017.

Chessel Practice

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 manager specialist advisor.

Background to Chessel Practice

Chessel Practice is located in a purpose-built medical centre at Sullivan Road, Sholing, Southampton, Hampshire. SO19 0HS.

This practice has a branch practice at 4 Chessel Avenue, Bitterne, Hampshire, SO19 4AA. During this inspection we did not visit the branch practice.

Chessel Practice holds a NHS General Medical Services contract for the provision of primary care services, and there are two executive partners within the practice partnership. The partnership is responsible for the delivery of these core services and the employment of all the staff within the surgery.

Integral Medical Holdings Ltd (IMH) is a GP led support company founded in 2015. The role of IMH is to provide a network of support to practices to enable them to function independently and meet the challenges and demands of the changing face of primary care. Since March 2016, Chessel Practice has been under the brand of IMH.

At the time of this inspection, the practice staff included the two male GP partners and a practice manager. The practice also had five salaried GPs, three of whom were male and two were female.

The previous registered manager had left the practice since our inspection in October 2016 and a new registered manager was in the process of registering with the Care Quality Commission at the time of this inspection.

The practice has three advanced nurse practitioners, one of which is a home visit practitioner. There are also two practice nurses and two health care assistants and a phlebotomist.

The clinical team are supported by a practice manager and a team of receptionists, typist and administration support staff.

The practice is also supported by regional staff from IMH as and when required.

Chessel Practice has an NHS General Medical Services contract to provide health services to approximately 11,484 patients in and around the east of the city of Southampton and surrounding area. The practice covers an inner city area with significant numbers of disadvantaged patients and is in the fourth most deprived decile nationally. This practice has a high percentage of patients aged between 0-19 years and 70 years and over.

The practice is open Monday to Friday from 8am to 6:30pm. Phone lines are open from 8am to 6.30pm Monday to Friday (excluding public holidays). The practice is closed between 1pm and 2pm on a Monday for staff training.

All consulting and treatment rooms are on the ground floor and there are appropriate facilities for disabled patients and baby changing.

The waiting area is large and has an open and calm feeling. There is a self-check in system with automatic opening entrance doors. The waiting area also has the entrance to the independent pharmacy.

Detailed findings

Same day appointments can be booked at any time from 8am on the day the patients need the appointment for. Routine appointments are available up to four weeks ahead with each GP.

Urgent appointments are also available for people who need them. Appointments can be made by phone, on line or by visiting the practice. The practice offered online booking of appointments and requesting prescriptions.

The practice offers telephone consultation appointments with the GP or nurses which can be arranged via the reception team. The practice also offers home visits if required and appointments with the practice nurses if the patient felt they did not need to speak with a GP.

The practice has opted out of providing out-of-hours services to their own patients and refers them to the Out of Hours service via the NHS 111 service.

Why we carried out this inspection

We undertook a comprehensive inspection of Chessel Practice on 27 October 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement for safe, effective, responsive and well led services and good for caring services. The practice was rated overall as requires improvement.

We undertook a further announced comprehensive inspection of Chessel Practice on 20 June 2017. To check that the practice had made improvements to the areas that required improvement.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 June 2017. During our visit we:

- Spoke with a range of staff including GPs, Nurses, administration and reception staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed information supplied to us by the practice to show they had made improvements.

Please note that the caring domain was not inspected at this inspection. There was no evidence or concerns that the previous rating for this domain had changed.

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 inspection in October 2016 we rated the practice as good for providing safe services.

Safe track record and learning.

The practice is now rated as inadequate for providing safe services.

There was a system in place for reporting and recording significant events, however this was not consistently effective.

- 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 practice was carrying out analysis of significant events. There were six monthly meetings to discuss significant events and we were told learning was shared. However, meeting minutes were not recorded with details of local reviews of significant events, what actions had been taken and who was responsible for those actions.
- The practice used an electronic system to record significant events with the information, action dates and review dates.

We reviewed safety records, incident reports and national patient safety alerts where these were discussed.

Although these matters were discussed in the practice we found no evidence that when things went wrong an action plan was put together to prevent recurrence. This meant that lessons were not always completely shared to make sure action was taken to improve safety in the practice.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information and a verbal and written apology.

Overview of safety systems and process.

The practice had systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. We saw that there were different versions of the policy being used, a practice policy and Integral Medical Holdings version. The children's safeguarding policy gave details of a lead GP who was no longer present at the site and the deputy as a GP who does not work at the practice. We were able to confirm that there was a current lead GP at the practice for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- A notice in the waiting room and on the website 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 maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- A practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- 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).
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice had a medicines manager who carried out regular 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.

Inadequate

Are services safe?

- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Although when issuing forms they were not always recorded as to whom they went to.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- Systems to monitor patient results were not always effective. We reviewed an audit of patients prescribed Lithium and who required blood tests completed at the correct times. This audit was run from October to December 2016 and identified that not all patients prescribed lithium had undergone the appropriate testing.

There were fourteen patients recorded as being prescribed Lithium at the practice. The audit checked these patients' records to see if they had had a blood test every three months. The audit identified that five patients had not received a blood test within the three month requirement. This was identified to the practice manager, who instructed a member of staff to check the records and provide immediate appointments for those patients to have blood tests.

We were informed that three of the patients had received their blood tests in the intervening time and the practice was following up appointments for the other two patients.

- The practice was able to supply evidence with regards to other high risk medicines that showed there were systems to monitor treatment appropriately and there was means of checking the repeat prescribing system to see that all patients on these medicines had blood tests done within the appropriate timeframe.

We reviewed five personnel files of staff who had been appointed after our last inspection and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients.

Risks to patients were assessed and managed for most aspects of the practice.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control.
- At the previous inspection in October 2016 we found that a Legionella risk assessment had been completed. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).The assessment, had been carried out on 26 February 2016 The practice had still not fully completed these recommendations.

Arrangements to deal with emergencies and major incidents.

- The practice had 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 an emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

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

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection in October 2016 we rated the practice as requires improvement for providing effective services because we found that not all staff had received a staff appraisal.

We issued a requirement notice telling the practice to improve in this area.

At this inspection we found that the practice had completed all staff appraisals.

However, the practice continues to be rated as requires improvement for effective services as improvements are required in other areas.

Effective needs assessment.

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. For example, NICE guidance for patients with atrial fibrillation.

Management, monitoring and improving outcomes for people.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results 2015-2016 were 84% of the total number of points available. The practice had a clinical exception rate of 6%. This was an improvement on the previous year. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

- 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 (01/04/2015 to 31/03/2016) was 59% compared to the clinical commissioning group average of 78% and national average of 78%.
- 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 (01/04/2015 to 31/03/2016) was 77% compared to the clinical commissioning group average of 90% and national average of 89%.

The practice gave us unverified QOF figures for 2016-2017 which showed that the practice had achieved 86% of the total number of points available. This showed that there was a small improvement in the QOF figures year on year.

We were supplied with some figures by the practice for 2016-2017. These had not been externally verified. At the time of this inspection there were no clinical commissioning group or national averages available for comparison.

- Performance data, supplied by the practice, for learning disability related indicators was 100% of the total number of points available.
- Performance data, supplied by the practice, for dementia related indicators was 100% of the total number of points available.
- Performance data, supplied by the practice, for diabetes related indicators was 63% of the total number of points available.
- Performance data, supplied by the practice, for mental health related indicators was 77% of the total number of points available.

The practice was working to increase these figures, but GPs we spoke with did not have knowledge of how the practice was performing with regards to QOF; however nursing staff were making changes to how they worked to try and improve outcomes for patients for example, procedures had been discussed at a nurses meeting. The practice then put into place diabetic clinics for patients with type one and type two diabetes three days a week at both practice locations and for patients to be called in for annual review on their birth month. Three letters were sent out to patients if they did not attend for review.

There was no identified lead for QOF outcomes, or quality improvements. This meant that there was no leadership to drive improvements in relation to performance on QOF.

We were told that there had been a number of clinical audits completed in the last two years. The practice

supplied details of audits of high risks medicine audits that had taken place, although the lithium audit had not been properly followed up to confirm that all patients had completed blood tests at the required intervals.

Effective staffing.

At our last inspection staff had the skills, knowledge and experience to deliver effective care and treatment however not all staff had received an appraisal.

At this inspection we found that:

- Staff had the skills, knowledge and experience to deliver effective care and treatment and staff appraisals had been completed by all staff.

We were shown an appraisals matrix which showed that all staff had now received appraisals and this was confirmed when speaking with staff and inspecting personnel files.

- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, appraisals, coaching and mentoring and facilitation and support for revalidating GPs.
- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice also employed two clinical support officers (CSO) whose role was to support the GPs around four key workflows, document management – predominantly hospital correspondence, laboratory result management, medicine management and report writing.
- The CSO role was intended to work closely with two key areas of the practice support functions – namely the Clinical Pharmacist and the Referral team. We saw an IMH Group South Region Clinical Support Officers Handbook which set out the role requirements and what CSO's were allowed to do.

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 a sample of 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. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice 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.

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 or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives.

- The practice identified patients who may be in need of extra support and signposted those to relevant services. For example: the practice had a visiting advanced nurse practitioner who visited patients in their own homes.
- 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.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to clinical commissioning group and national averages.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice supplied unverified figures for 2016-2017. Uptake for the cervical screening programme was 95%, which was above the national average of 82%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer.
- There were 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.
- 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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

At our inspection in October 2016 we rated the practice as good at providing caring services.

At this inspection the practice continues to be rated as good for providing caring services.

Kindness, dignity, respect and compassion.

- We observed 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.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Results from the national GP patient survey July 2017 showed patients felt they were treated with compassion, dignity and respect.

Care planning and involvement in decisions about care and treatment.

- Patients informed 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.
- Results from the national GP patient survey in July 2017 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 example:
- 88% said the last nurse they saw was good at explaining tests and treatments compared to the clinical commissioning group (CCG) average of 89% and national average of 90%.
- 92% said the last nurse they saw was good at giving them enough time compared to the CCG average of 91% and national average of 92%.
- 96% said that they had confidence and trust in the last nurse they spoke to compared to the CCG average of 97% and national average of 97%.

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

Patient and carer support to cope emotionally with care and treatment.

- Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice had recorded 440 patients on their carers register (171 males and 269 females) this represented over 3% of the practice population.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our inspection in October 2016 we rated the practice as requires improvement for providing responsive services because we found that patients were having difficulty making appointments at the practice via the telephone system.

At this inspection we saw that improvements had been made and were continuing to improve in this area. The practice continues to be rated as requires improvement for responding to people's needs as improvements are required in other areas.

Responding to and meeting people's needs.

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 where these were identified.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had employed salaried GPs who were now bringing continuity to patient care and patients reported that they were able to see the same GP at appointments.
- The practice had three advanced nurse practitioners, one of which was a home visit practitioner, who triaged home visits with the assistance of a GP to ensure that decisions were within their competencies.

Access to the service.

The practice was open Monday to Friday 8am to 6:30pm. Phone lines were open from 8 am to 6.30pm Monday to Friday (excluding public holidays). The practice was closed between 1pm and 2pm on a Monday for staff training.

Same day appointments could be booked at any time from 8am on the day the patients needed the appointment for. Routine appointments were available up to four weeks ahead with each GP.

Urgent appointments were also available for people who needed them. Appointments could be made by phone, on line or by visiting the practice. The practice offered online booking of appointments and requesting prescriptions.

The practice offered telephone consultation appointments with the GP or nurses which could be arranged via the reception team. The practice also offered home visits if required and appointments with the practice nurses if the patient felt they did not need to speak with a GP.

The practice had opted out of providing out-of-hours services to their own patients and refers them to the Out of Hours service via the NHS 111 service.

Results collected between January and March 2017 from the national GP patient survey in July 2017 showed that patient's satisfaction with how they could access care and treatment was below national averages. The number of patients who responded represented about 0.8% of the practice's patient list.

- 43% of patients who replied were satisfied with the practice's opening hours compared to the national average of 80%. 19% of patients who replied were neither satisfied nor dissatisfied, 30% were either fairly dissatisfied or very dissatisfied and 7% were not sure when the practice was open.
- 17% patients said they could get through fairly easily to the surgery by phone compared to the national average of 74%. 54% said this was not at all easy.

We had previously raised these figures with the practice who told us they had placed patient satisfaction on the practice's continuous professional development plan and were starting to make improvements to patient experience. The practice told us they felt that feedback from patients was crucial and were learning from that by implementing changes to improve patient experience. For example; Friends and family survey responses for April, May and June 2017 showed that more patients would recommend the practice rising from 57% in April 2017 to 68% in May 2017.

The practice had worked to improve the phone system and the practice had put additional receptionists taking calls at peak times on four incoming lines. The practice manager was continuing to monitor and audit call waiting times and

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

missed calls and we were told 80% of calls were being answered within a reasonable time compared to 60% in January 2017. The practice was also employing more reception staff to help patients make appointments.

Call waiting times and unanswered calls had been an agenda item on the new patient participation group (PPG) meeting. We spoke with two members of the PPG who told us that the practice was supporting them by assisting with meetings and wanted feedback to help the practice manager to improve care for patients. They said that the practice had improved greatly in the past few months and the telephone system had improved with the introduction of a clearer set of instructions of what buttons to press when calling the practice in order to get to the correct department to deal with the patients requirements. For example booking an appointment, making a general enquiring or obtaining a blood test result.

Listening and learning from concerns and complaints.

The practice had an effective system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. Examples seen were complaints and comments leaflets available from reception or online. Also available online was a complaints form which could be filled in by the patient.

We looked at thirteen complaints received since our last inspection and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency when managing the complaint. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, the majority of complaints were about the telephone systems which had been reviewed and the practice was working to improve answering times.

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 inspection in October 2016 we rated the practice as requires improvement for providing well led services. We found that although the partners in the practice had the experience and capability to run the practice and ensure high quality care, governance arrangements and risk management were not fully embedded. The partners were not always visible in the practice and staff told us they were not always approachable or took the time to listen to members of staff.

There was a changing leadership structure still being put in place in place and staff in general felt supported by management but were still uncertain about the future.

At this inspection, we found that improvements had not been made and the practice remains rated as inadequate for well led services.

Vision and strategy.

The practice had a vision to deliver high quality care and promote good outcomes for patients.

- There had been a change of direction and leadership from March 2016 this had continued since our last inspection in October 2016.
- Chessel Practice was now under the brand of Integral Medical Holdings (IMH) and had two registered partners who were GPs. However, we found that the two registered partners at Chessel Practice did not actually complete any sessions of work at the practice.
- Chessel Practice holds a NHS General Medical Services contract for the provision of primary care services, and there are two executive partners within the practice partnership. The partnership is responsible for the delivery of these core services and the employment of all the staff within the surgery.
- All the GPs performing clinical sessions were salaried GPs and we were told that there was a lead GP who was available for support. This GP was a partner registered at another practice within the IMH brand and not registered with the Care Quality Commission as a partner at this practice.
- The practice had a mission statement which was displayed in the waiting areas and senior staff knew and understood the values. However, some staff we spoke with were not sure of the mission statement and were unsure what responsibilities the GPs had and who to go to with concerns.
- Salaried GPs were unsure of who they should contact for clinical leadership, although we were told at the time of this inspection by the practice manager that the GP from the other practice was always available to assist with clinical leadership or issues.
- The practice had a strategy and supporting business plans which reflected the vision and values. However as there was no clear day to day clinical leadership we found that these business plans were not always being implemented. For example the legionella assessment conducted in February 2016 had made recommendations that had not been completed since our last inspection.
- We saw that meeting outcomes were not recorded properly and minutes of the meetings were not fully completed.
- When things went wrong there was no record of actions being raised to ensure that somebody was working to prevent the same things happening again and making sure all relevant staff were made aware of any policy or process changes.

Governance arrangements.

The practice had an overarching governance framework but this was not fully embedded. Improvements were seen for the delivery of the strategy and patient care:

- Practice specific policies were implemented and were available to all staff although there were policies that required reviewing. For example we looked at the safeguarding policies and saw that there were different versions of the policy being used, a practice policy and Integral Medical Holdings version. The children's safeguarding policy gave details of the lead GP who was no longer present at the site and the deputy as a GP who no longer worked at the practice.

Leadership and culture.

The partners in the practice were not present during this inspection. We were not able to evidence that they had the experience and capability to run the practice and ensure high quality care. Governance arrangements and risk

Are services well-led?

Inadequate

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

management were not fully embedded. The partners were not always visible in the practice and staff told us they were not always approachable or took the time to listen to members of staff.

The registered GP partners had minimal knowledge of what was happening during day-to-day services at the practice and did not have the capacity or capability to lead effectively. There was a lack of clarity about authority to make decisions.

The arrangements for governance and performance management did not always operate effectively. There had been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance. For example; there was no effective leadership driving improvements in relation to performance on the Quality and Outcomes Framework.

The provider was aware of and complied with the requirements of the Duty of Candour. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

Staff in general felt supported by management but were still uncertain about the future. The partners were not visible in the practice or provided support to staff; this was carried out at a local level by the practice manager.

- Staff told us there was an open culture within the practice and they had the opportunity to raise issues with the practice manager. Most we spoke with felt confident in doing so.
- Staff said they felt respected, valued and supported at the time of our visit. Staff were sometimes involved in discussions about how to run and develop the practice.
- The practice manager had now completed a programme to make sure all staff had received an appraisal in the last 12 months.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had found difficulty in retaining patients to take part in a patient participation group (PPG). A new group started on 7 March 2016. We saw documentation that showed the new PPG was meeting regularly and producing documentation with comprehensive proposals for the future of the practice, including completing patient surveys and submitting proposals for improvements to the practice management team.

Continuous improvement.

The practice manager and team were trying to be forward thinking and had started to implement a focus on continuous learning and improvement. For example the practice had a continuous professional development plan and practice action plan which was being reviewed and updated.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Assessments of the risks to the health and safety of services users of receiving care or treatment were not being carried out. In particular: Risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so. Risk assessments should include plans for managing risks. Medication reviews must be part of, and align with, people's care and treatment assessments, plans or pathways and should be completed and reviewed regularly when their medication changes. An audit had been undertaken of patients prescribed lithium to check they were having blood tests completed at the correct times. This audit identified that not all patients prescribed lithium had undergone appropriate testing. All patients must receive testing at correct intervals. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

• There was no system for local clinical oversight at the practice for nursing and GP staff in order to be able to maintain and improve care and treatment for patients

• The clinical staff were not offered opportunities to meet regularly on an informal or formal basis to discuss clinical concerns and risks or give feedback on improving the quality of the service provided.

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