Dr Iain Hotchkies

Quality Report

36 Mersey Bank Avenue,
Chorlton,
Greater Manchester,
M21 7NN
Tel: 0161 445 5559
Website: The practice does not have a website

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a new comprehensive inspection of Merseybank surgery on 14th July 2015. We have rated the overall practice as inadequate.

Specifically, we found the practice inadequate for providing safe, responsive and well led services. It was also inadequate for providing services for all the six population groups. Improvements were required to caring and effective services.

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

- There was insufficient reporting, recording and reviewing of significant events and staff were not encouraged to follow formal processes and promote a learning culture.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. We found concerns in safeguarding, infection control, training, medicine management, access and quality and monitoring systems.
- We found the practice had not taken all measures to identify, assess and manage risk. For example, the practice did not have robust systems for checking and recording medicines held at the premises or managing health and safety.
- Prescriptions were not kept securely in line with national guidelines.
- The practice did not have systems in place to monitor the quality of the service or determine whether the patients received the best treatments available to them.
- All the patients we spoke with were very satisfied with access to appointments and told us that they were very happy with the service, the GP and the staff. CQC

Summary of findings

comments cards provided positive feedback; however the GP patient survey results, reviews left on public websites and the friends and family test were not always positive.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- There was no clear vision and strategy and no plans for the next twelve months or next five years other than to carry on as they were currently.
- There was no patient participation group and no regular monitoring that patients were receiving a service they were happy with. Although there was a formal complaints procedure, complaints were mostly dealt with informally.

There were areas of practice where the provider needs to make improvements.

Action the provider MUST take to improve:

- Implement a process to review significant events annually and disseminate learning to practice staff
- Ensure medicine management systems are reviewed and reflect national guidelines.
- Ensure appropriate infection control systems are in place, in line with national guidelines.
- Provide safeguarding training to all staff at the required level for their role.
- Ensure there are systems in place to regularly assess and monitor the quality of the services making sure policies and procedures are regularly reviewed as to their effectiveness and ensuring there is a clinical audit process in place with evidence of actions taken in improving patient care.
- Ensure there are processes in place to identify, assess and manage risks relating to health, welfare and safety of patients.
- Ensure staff receive regular appropriate training, specific to their role.
- Undertake and record risk assessments, including those relating to health and safety and risks to patient safety.
- Review responses from patients regarding the accessing appointments in order to make improvements to the service provided.
- Regularly obtain patients' views and act on the feedback received to improve the services provided for example with the development of a patient participation group.

Action the provider should take to improve:

- Review staffing levels to ensure that there are enough staff to carry out the duties required to run the practice effectively.
- Provide information to patients, in the form of easily accessible literature, posters and leaflets, about the practice, the services offered and signpost patients to other services in the area.
- Hold regular meetings with staff, which are minuted, to discuss all aspects of the practice which relate to patient care and safety.
- Risk assess and evidence which staff should have Disclosure and Barring Service (DBS) checks.
- Provide chaperone training to staff who are required to undertake chaperone duties.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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 safe and improvements are required. Staff were not encouraged to raise concerns and report incidents and near misses and the practice were not able to evidence a safe track record over time. Only two events of significance were recorded over a number of years although we found evidence that more had occurred. There was not enough monitoring to ensure safety in relation to medicines, infection control, equipment, staffing and potential risks. There was not enough evidence that learning took place and was shared when things went wrong to minimise re-occurrence in the future.

Patients were very happy with the care they received and were very complimentary about the GP, the access to the service and the staff at the practice. Staff were happy at the practice, felt supported and felt adequately equipped to carry out their role.

Are services effective?

Inadequate

The practice is rated as inadequate for effective and improvements are required. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed they were performing as expected and staff said that the QOF data was regularly reviewed. Patient outcomes were hard to identify as little or no reference was made to audits and there was an absence of evidence to demonstrate that the practice was comparing its performance to others, either locally or nationally. Although appraisal took place there was limited recognition of the benefit of an appraisal and support for any additional training that may be required

Are services caring?

Requires improvement

The practice is rated as requires improvement for caring as there were areas where improvements should be made. Data showed patients rated the practice lower than others for some aspects of care. There was no information available to help patients understand the care available to them, help them make informed choices and encourage them to explore alternative treatment methods.

All patients we spoke with said they were treated with compassion, dignity and respect. All felt supported and listened to. All reported that they received the care and treatment they asked for. They held

Summary of findings

the GP in very high regard and were very happy with the attitude of the reception staff and the nurse. A small number of patients had formally complained about the GP but had chosen to remain with the practice as they were happy with access

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for responsive and improvements are required. Information about patients' needs were not used to inform how services were planned and delivered. For example staff were not adequately trained to support patients that might present with learning disabilities or mental capacity issues. The practice did not pro-actively seek feedback or comments from their patients and complaints were not used as an opportunity to learn. Male patients were not offered a chaperone service.

However, patients were able to access treatment in a timely way with an easy to use appointment system. The GP offered open access with no appointment requirement every morning and people were able to book in, go away, and come back to save them waiting. We were told by patients we spoke to and by the GP that the amount of time given to each appointment was the amount of time needed at the consultation. In the afternoon appointments could be pre-booked at ten minute appointment interval times.

Are services well-led?

Inadequate

The practice is rated as inadequate for well-led and improvements are required. The practice did not have a clear vision and strategy in place. There was no monitoring of performance of the practice. Systems for identifying, capturing and managing issues and risks were not effective. The GP worked in isolation treating patients and the practice manager was responsible for everything else. There were no staff discussions about the importance of quality and safety and things that could be done to improve the service. There were a number of policies and procedures to govern activity but they were not all signed, up to date or regularly reviewed. The practice did not proactively or formally seek feedback from staff. There was no patient participation group. The staff, including the GP, did not know about things that did, or could go wrong, and were not aware of the issues arising out of the inspection.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

The practice had a lower than average proportion of patients who were over the age of 65. The practice did not participate in any enhanced services for this population. Patients in this age group were offered the same treatment as the rest of the practice population. There were no nursing homes and no specific provision for patients living in sheltered accommodation or nursing/ residential homes.

People with long term conditions

Inadequate

The provider was rated as inadequate for the domains of safe, effective, responsive and well-led with requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of patients with long term conditions.

The practice used the Quality and Outcomes Framework (QOF) to flag up patients with long term or chronic conditions. The practice did not participate in any enhanced services for this population. Patients in this population group were offered the same treatment as the rest of the practice population and long term conditions were reviewed during routine times of open surgery.

Families, children and young people

Inadequate

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

That practice had a higher than average proportion of patients in the age group of 5 to 29. The GP told us that they worked in collaboration with other services, such as social services, if and when required. The GP undertook all child vaccination and immunisations and used the Quality and Outcomes Framework (QOF) to monitor the uptake. Data showed that results for Dtap/IPV

Summary of findings

Booster and MMR Dose 2 were lower (at 80%) than the Clinical Commissioning Group (CCG) average (which was 92%). Families and young children could be seen quickly at the practice through the open access surgeries between Monday and Friday.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for the domains of safe, effective, responsive and well-led with requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of working age people, including those recently retired and students.

The practice did not participate in any enhanced services for this population group. Access for patients who were working was good and all patients spoken with were happy that they could be seen quickly at the practice through the open access surgeries between Monday and Friday. There was no website for the practice, but appointments could be made and prescriptions could be ordered on line. There was a process for new patient registration and the practice manager told us that a new patient health check was available for new patients. This was usually done by the GP at initial consultation.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for the domains of safe, effective, responsive and well-led with requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

The GP told us that people in vulnerable circumstances were treated appropriately and the GP told us he would signpost these patients and provide options for different services when required. There were no specific provisions for patients in this group such as registers of patients living in vulnerable circumstances. The GP told us that they knew the patients at the practice very well. We saw that the electronic patient record had the facility to place alerts on patient records and we saw that alerts were used to highlight patients who may be carers, or those who may be cared for. Safeguard training was not up to date for the GP or non clinical members of staff. However staff we interviewed responded that they knew what to do if they had any concerns.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate 

The provider was rated as inadequate for the domains of safe, effective, responsive and well-led with requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

The practice did not participate in any enhanced services for patients in this population group. The GP told us that they had no formal Mental Capacity Act training and although they would be happy to involve patients in discussion they would signpost them to more appropriate services if they encountered a difficult situation.

Summary of findings

What people who use the service say

We spoke to 14 patients, whose age range and treatment requirements varied. Many of them had been with the practice more than twenty years and their families were also patients there. All the patients without exception held the GP and the practice staff in high regard and the comments on the CQC comments cards we reviewed were also positive. Patients said they were very well supported, were very happy with the access and were happy with the staff.

They felt the they had a very good GP who listened and never rushed them. One patient commented on how hard working the GP was and how compassionate he had been when the patient's partner had passed away. Another patient commented that they hated it when the GP was on holiday and a locum came in, which had not happened since 2012.

Results from the GP patient survey showed that the patients were very happy with the access to the service. The practice scored best on the following three points :

- 96% of respondents found it easy to get through to the surgery by phone. The local average was 67% and the national average was 73%.
- 90% of respondents were satisfied with the surgery's opening hours. The local average was 73% and the national average was 75%
- 84% of respondents described their experience of making an appointment as good. The local average was 69% and the national average was 73%.

The practice scored lowest in the following :

- 45% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: 62% National average: 65%

64% of respondents would recommend this surgery to someone new to the area

Local (CCG) average: 76% National average: 78%

83% of respondents say the last nurse they saw or spoke to was good at listening to them Local (CCG) average: **91%** National average: **91%**

Areas for improvement

Action the service MUST take to improve

- Implement a process to review significant events annually and disseminate learning to practice staff
- Ensure medicine management systems are reviewed and reflect national guidelines.
- Ensure appropriate infection control systems are in place, in line with national guidelines.
- Provide safeguarding training to all staff at the required level for their role.
- Ensure there are systems in place to regularly assess and monitor the quality of the services making sure policies and procedures are regularly reviewed as to their effectiveness and ensuring there is a clinical audit process in place with evidence of actions taken in improving patient care.
- Ensure there are processes in place to identify, assess and manage risks relating to health, welfare and safety of patients.
- Ensure staff receive regular appropriate training, specific to their role.
- Undertake and record risk assessments, including those relating to health and safety and risks to patient safety.
- Review responses from patients regarding the accessing appointments in order to make improvements to the service provided.
- Regularly obtain patients' views and act on the feedback received to improve the services provided for example with the development of a patient participation group.

Summary of findings

Action the service SHOULD take to improve

- Review staffing levels to ensure that there are enough staff to carry out the duties required to run the practice effectively.
- Provide information to patients, in the form of easily accessible literature, posters and leaflets, about the practice, the services offered and signpost patients to other services in the area.
- Hold regular meetings with staff, which are minuted, to discuss all aspects of the practice which relate to patient care and safety.
- Risk assess and evidence which staff should have Disclosure and Barring Service (DBS) checks.
- Provide chaperone training to staff who are required to undertake chaperone duties.

Dr Iain Hotchkies

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 and an expert by experience. An expert by experience is someone who uses health and social care services.

Background to Dr Iain Hotchkies

Merseybank Surgery was previously inspected under the old methodology of the Care Quality Commission on 29 August 2013. It was found that improvements were required around the recruitment of staff. The practice was re-inspected in May 2014 to check that the necessary improvement had been made to the regulation regarding the recruitment of staff and was found to have complied with the regulation at that time.

The Surgery is situated in a deprived area of Chorlton in south Manchester. It is located in a row of shops and has disabled access and toilet facilities. Dr Hotchkies is a single-handed, male practitioner who has provided GP services at this location for over twenty five years under a General Medical Services contract. The practice population is around 2,600 patients and has a higher than average proportion of patients between the ages 15 and 49. The highest group of patients are aged between 25 and 29 and this is also higher than the local and national average.

There is a part time practice nurse for three hours a week, a practice manager and three reception/secretarial staff.

The practice does not offer surgical procedures, maternity or midwifery services or minor injury treatments. These could be accessed through the local community services. The surgery is open from 8.30am until 6pm Monday to Friday (except Wednesdays). On Wednesday the practice close at 1pm. Patients are directed to out of hours services when the practice is closed after 6pm and at the weekend.

Patients have access to an open surgery from 9.15am until 11.30am Monday to Friday and appointments are pre-bookable in the afternoons (except Wednesdays). The practice do not have a website but offer online appointment booking and repeat prescriptions on line. The practice does not have a Patient Participation Group.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The service was previously inspected on 29 August 2013 and actions were required around the recruitment of staff. In May 2014 we went back to check that improvements had been made to that requirement. During that inspection we looked at records where we last found non compliance and found that improvements had been made. We also found as follows:

- The practice manager informed us that reception staff no longer undertook a chaperone service and that this was provided by the part time practice nurse. We saw that existing reception staff did not have DBS checks

undertaken. As a practice the GP and practice manager had judged that the reception staff did not require DBS checks. There was no written risk assessment containing this information in place.

The information above is relevant to this inspection.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice including the previous inspection reports and other information on our records management system. We asked other organisations to share what they knew and considered the information provided. We carried out an announced visit on 14th July 2015.

During our visit we spoke with the sole GP, the practice manager and two reception staff who were employed by the practice. We also spoke with 14 patients who used the service and observed how people were being treated. We reviewed 22 comment cards where patients and members of the public shared their views and experiences of the service and looked at the results from the Friends and Family test

Inadequate

Are services safe?

Our findings

Safe track record

The practice was not able to demonstrate a safe track record over time. There was a system to record and report accidents and incidents but there were none recorded. We were shown a copy of the significant event review process but were told that the practice had opted out of sharing these with the Clinical Commissioning Group (CCG) because they did not have the minimum three significant events per year to report. Significant events were recorded only by the GP who had his own tools on the internet. We were told that everything of note was recorded on the patient's individual electronic records. This did not give the practice an opportunity to monitor the information in a systematic way to see if trends were apparent and changes could be implemented to reduce re-occurrence of any events in the future. Staff we spoke to had an awareness of significant events but did not understand their obligation to report them in a formal manner and were not encouraged to do so.

Learning and improvement from safety incidents

Staff were not encouraged to record and report events of significance and they were not formally monitored. An accident book was available but there were no reported accidents over the past 12 months. The practice had been in operation for 25 years and most of the small number of staff had been there for 10 years or more.

A significant event protocol was available but it was not used. The practice manager told us that only the GP would decide if an incident was significant and needed to be recorded. Despite opting out of the enhanced service to report three events to the CCG (because three events did not occur at the practice in any year), the GP had still recorded two events of significance in May 2015, one which was clinical and one which was an administration issue.

In relation to the clinical incident, the GP had prescribed a medicine which could have had contra-indications for the patient. They realised the possible risk after prescribing the medicine when a warning was displayed on the electronic system. They had sought advice from another health professional treating the patient who had confirmed that no harm had been caused. The GP had taken learning from the incident that they should be more vigilant when initiating this medicine. However, more learning could have been explored, such as extra vigilance when initiating any medicine and ensuring that contra-indications were always explored before prescribing.

The administration issue was a simple human error and was discussed with the staff concerned. Learning taken from the incident was that the staff member should be more vigilant when doing the job in question. However more learning could have been explored, such as sharing the incident with all staff to ensure all staff were as vigilant, and ad-hoc monitoring of patient records to ensure that other similar errors were not made.

There were no formal meetings about significant events, no formal sharing with outside partner/agencies and no encouragement to staff that events should be reported, recorded and monitored to check for trends, increase learning opportunities and reduce the risk of the same or similar event happening again in the future.

We saw minutes from some clinical meetings (CCG Patch meetings) which showed that the GP had achieved areas of learning. These included information about nasal steroid techniques where he discovered he had been giving incorrect advice over a number of years. This was a significant event. It was not recorded as such and the information had not been shared with anyone other staff at the practice. This information was received post inspection and we did not have an opportunity to discuss it with the GP.

Reliable safety systems and processes including safeguarding

We saw that there was a resource folder with safeguarding information dated 24th April 2015 available to staff in the practice manager's office. The folder had details of persons to contact in the event of concerns about children and adults, flowcharts with clear instructions, details for patients of what to do in the event of domestic abuse, information about paediatric out of hours services and information about training for staff. None of this information was displayed for staff and/or patients in the reception area or the waiting room although they knew where to go if they needed to get it.

The GP was the lead for safeguarding in the practice and told us that they had completed training in level 1 and 2 recently and were due to have update training at level 3. They did not present any evidence or certification of any

safeguarding training previously undertaken. We saw from the resource folder that level 3 safeguard training was available in early 2015 but the GP had not been pre-booked on this by the practice manager. The practice manager informed us that the GP was responsible for their own personal development and training and she would not know if or when it was due for review.

Staff had contact telephone numbers for safeguarding teams in their personal address books but they could not confirm that these numbers were the most up to date and there were no easy to access posters or flow charts in the reception or waiting room. All policies and procedures were available electronically in a shared folder and accessible from the desktop of staff computers but these did not hold the same information contained in the resource folder. Staff demonstrated a level of understanding about safeguarding and what to do in the event of any concerns which would always be reported to the practice manager or the GP. They could not confirm when they last received safeguard training, how they received it or at what level. We saw from the resource pack, that a child sexual exploitation course was available up to 8th July 2015 but staff had not been encouraged to attend and were not booked on the course.

We saw from the practice statement of purpose that they offered a chaperone service. However there was no information in the patient information leaflet that we were given and there were no posters in the waiting room or consulting rooms with advice for patients about chaperone services. The GP told us that a chaperone was always offered to women during examinations above the waist and that Intimate examinations were always done with a nurse present. The nurse was only employed for three hours a week. The practice manager and practice staff told us that they did not carry out chaperone duties as they had not been trained to do so. However, this was contradictory to information provided by the GP and patients we spoke to who told us that a receptionist had been present during an intimate examination. They did not however say when this had been.

We spoke to the practice manager and the reception staff and explained the requirements of a chaperone. None of the practice staff had a current disclosure and barring service (DBS) check.

The GP did not attend any safeguarding meetings but reported that safeguarding incidents were common in Manchester. They provided examples of where they had contacted social workers or social services when they had concerns to report.

Medicines management

We saw that the practice had an appropriate fridge to store vaccines and other medicines that may need to be kept at a specific temperature. We saw that there was a cold chain protocol in place and the fridge temperature was checked twice daily to ensure it remained within the required limits. There were contact details on the fridge informing staff who to contact if the temperature went outside the acceptable range and a temporary fridge was available in the event of any failure.

There were checks in place to ensure that the medicines kept in the fridge were within the correct dates and each member of staff understood their responsibility in relation to that. The checks were not effective. On the day of the inspection we checked the fridge contents and found medicines that were not in date. We pointed these out to the practice manager who removed and disposed of them as per the practice removal and destruction process.

We found several other medicines on the premises that were out of date. Most of these were stored in the cupboards, drawers and trolley in the nurse's room and on the nurse's desk.

Blank prescription forms were kept by the GP and were not logged in and out appropriately. Prescriptions used in the electronic system were not handled in accordance with national guidance and were not tracked through the practice and kept securely at all times. Following the inspection the practice put systems in place to resolve this.

Cleanliness and infection control

The practice appeared clean and hygienic and patients we spoke with were very happy with the environment. The practice had an infection control policy. The content of the policy was minimal and It was not dated, reviewed or signed. The policy did not adhere to the current infection control requirements in general practice. The policy did not state that an annual audit of the premises should be undertaken and there was no evidence that either an in-house or CCG infection control audit had taken place.

The policy stated that a random and unannounced inspection should be undertaken by the infection control lead on a bi-monthly basis and the findings should be shared. There was no evidence that this bi-monthly inspection was carried out although the practice manager told us that she informally checked all areas for signs of any cleaning required.

The policy stated that the practice would undertake to maintain the equipment, medicines and procedures to the standards detailed within the checklist. There was no checklist to refer to and we found that equipment and medicines were not maintained appropriately. We found needles, cutter blades (used for removing stitches), sterile utensils and a box of specula which were a number of years out of date.

We spoke to the phlebotomist who undertook a clinic on the day of our inspection. They had no issues with infection control at the practice and reported that staff were very helpful. They told us that the practice left a box of needles, bottles and other things required for the clinic on the desk in the room being used to take blood. There was no evidence to show that the equipment left for the clinic was checked to see whether it was in date and the phlebotomist said they did not check the equipment that was left for them as they presumed it would be appropriate.

The practice manager was the infection control lead and had undertaken training of infection control in general practice in 2013 but had not undertaken any annual training updates. There was no evidence to support that they received infection control updates on a regular basis or passed them to the appropriate members of staff. There was no evidence that all staff at the practice had received annual infection control training as stated in the infection control policy.

We spoke with the cleaners of the premises and saw that they followed a daily, weekly and monthly cleaning schedule. They ticked and signed a list when the jobs were completed. We asked the cleaner if any spill kits required for cleaning urine or vomit spills, were available, and we were told that there were none. Privacy curtains were not disposable and, according to the practice manager, were cleaned approximately six monthly. The curtains looked clean but there were no dates on them to say when they were last cleaned or by whom. There was nothing to say whose was responsible for making sure that curtains were cleaned regularly. There was no evidence of legionella testing or a risk assessment being undertaken.

The practice had extracted key points on infection control from available guidance and used this as a guideline of requirements should there be an outbreak of influenza or a pandemic occurrence. These were not a part of the infection control policy and there was nothing to say where they had been obtained or that they were up to date.

We saw that appropriate hand washing and sanitisation gels were available and sinks in treatment and consultant rooms had elbow-use taps. Hand washing posters were displayed at each designated hand basin. Appropriate sharps boxes were fixed to the walls in treatment rooms for the disposal of needles. There were no posters or protocol within the infection control policy with information on what staff should do in the event of a needle stick injury. There were no reported incidences of needle stick injury.

Equipment

We spoke to administration staff and to the GP who told us they had enough equipment to enable them to carry out their daily duties. This included diagnostic examinations, assessments and treatments by the GP. The nurse worked three hours per week and was not available on the day of our inspection.

We saw that administration staff had computers with access to an electronic patient record and shared hard drive. In the nurse's room we saw an appliance for recording blood pressure, a set of non medical scales, an appliance for measuring height and a set of medical scales. There was no records of calibration. On the computers and other electrical appliances there was no record of testing. We asked the practice manager about this and they reported that calibration and portable appliance testing was not undertaken. The fridge containing medicines had not been calibrated since it had been purchased around three years ago.

We were sent evidence that all equipment and portable appliances were tested and calibrated immediately following our inspection.

Staffing and recruitment

Staff at the practice consisted of the sole GP, the practice manager, a nurse for three hours per week and three

reception staff. The most recent member of staff was the part time nurse working three hours per week. We were told she had been working at the practice for approximately 13 weeks, initially as an agency nurse and currently as an established member of staff. (We saw a check which had been carried out by the nurse on 16/2/2015 and established this was at least 21 weeks before the inspection date). We looked at their personnel file and the file of the most recent receptionist who had been employed for three years. Most of the required documentation was available. However the contract for the practice nurse was not yet signed, their induction had not been completed and proof of training documentation had not been received. The practice manager told us they had not got round to receiving this information because of the short amount of hours the nurse worked each week, but they had information from the nursing agency that satisfied them that the nurse was suitable for their role. We saw that the nurse's professional registration was up to date.

A current DBS check had not yet been received for the new nurse although there was one available from the nursing agency which was current. We looked at the files of previous nurses employed by the practice and saw that the required documentation was available.

No one else at the practice had a DBS check. We advised the practice manager of the risks related to staff who were not DBS checked and the requirement for those who carry out the role of chaperone.

Monitoring safety and responding to risk

We asked the practice how they established if they had enough staff and were told that there were enough staff to complete the work required to run the practice effectively. We found that this was not the case as there were several areas of work which were not being completed, such as recording, monitoring, managing and responding to risk.

The practice had a health and safety policy which clearly outlined the responsibilities of staff. The policy was not dated and outlined responsibilities which were not being managed. These included the checking of medicines, in the first aid box for example, which were supposed to be checked monthly.

The practice did not have robust systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Medicines management, infection control, staffing, dealing with emergencies and the maintenance and calibration of equipment were not checked regularly and were not managed effectively to reduce potential risks.

Arrangements to deal with emergencies and major incidents

All staff had undertaken cardiopulmonary resuscitation (CPR) training in March 2013 but this had not been updated since then. Staff had been advised to contact 999 in the event of any incident. There were no examples where this had been necessary.

An automated external defibrillator (AED) was available at the practice but staff were unsure where it was kept. We saw that it was stored in its original box under the practice manager's desk and was neither on display, or quickly and easily accessible. Staff had not been trained in its use and it was not checked on a regular basis to ensure it was in good working order.

There was no oxygen on the premises although we saw two pocket face masks which would be required for use with oxygen or a nebuliser to help someone with breathing difficulties. The masks were dusty and had not been checked or cleaned to ensure they were fit for use. No risk assessment had been undertaken to see whether oxygen or a nebuliser were required at the practice. No incidents had been recorded and none were reported by any of the staff.

We checked the medicines in the emergency medicine box in the nurse's room. It contained adrenaline for injection and hydrocortisone which would be used to deal with an anaphylaxis shock or an acute episode of asthma. There were no other medicines available such as benzylpenicilllin to treat suspected bacterial meningitis or a salbutamol inhaler to treat an acute asthmatic incident. The box also contained a syringe and a needle which were out of date (February and November 2014) and dressings which were not sealed and were not sterile. The box of medicines had last been checked on 6th February 2015.

The fire equipment had been checked and replaced on 3rd March 2015 and was in good working order according to the evidence seen. Staff knew what to do in the event of fire. However, there were no signs in the waiting room for patients showing them what should be done in the event or suspicion of fire. There was no date of the last time staff had received fire training, and the practice manager told us it had not been done in a long time.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP outlined their rationale for treatment and told us they provided a general medical service offering routine medical checks with a holistic approach to care and treatment. That covered a wide range of conditions which required long term treatment and care. The GP's priority was to ensure that the care was on-going and appropriate. Each patient's needs were assessed during their consultations with the GP and through conversation and review of any current medical issues. Their treatment was planned to meet needs identified at the consultation and the patients we spoke with told us they were reviewed at regular intervals to ensure their treatment remained effective. We received several written examples from the GP, post-inspection, where patients needs had been identified during consultation and the care and treatment offered was shown to be effective.

Patients we spoke with told us they were happy that their needs were assessed and met appropriately. They all held the GP in high regard and felt that he knew them well, understood their needs and was able to provide the most appropriate treatment.

We discussed with the GP how National Institute for Health and Care Excellence (**NICE**) guidance and other medical alerts and updates were received into the practice and whether it was followed. We were told that the practice manager received all guidance and alerts and disseminated them. All clinical alerts and updates were directed to the GP. The GP was unable to describe examples of any guidance that had recently been accessed, downloaded, reviewed or referred to in connection with any treatment provided to his patients. We were therefore unable to obtain evidence that the GP referred to NICE guidance and local guidelines when treating patients. When asked about new medicines the GP told us they didn't prescribe any new drugs.

Management, monitoring and improving outcomes for people

The CCG medicines management(MM) team attended the practice regularly, carried out audits of certain medicines and advised the GP of actions to be taken. We saw an asthma audit carried out in October 2014 by the MM team. Following the audit, patients were identified, and their records flagged, so that the GP could review their inhaler usage, face to face, when next seen. The reasons for their inhaler was explored and their treatment was adjusted and maximised. The practice had a process in place to call the patients with asthma but did not offer any evidence to show the number of patients called, the number of patients reviewed and the number of patients whose treatment had been changed. There were no plans for a re-audit to check whether or not the changes were effective.

The practice used the Quality Outcomes Framework (QOF) to manage and monitor patients with conditions that may require treatment. A QOF diary had been introduced by the GP and provided specific actions for staff members to take on specific days of each month to search and recall patients. Administration staff followed these instructions and shared key roles such as data input, read coding, recalling patients and carrying out certain safety checks. Tasks in the QOF diary included contacting patients with chronic kidney disease who required a blood pressure review, patients with asthma who required an inhaler review and patients with diabetes who required a cholesterol check. General health checks were done opportunistically when patients attended for consultation about other issues.

We received information (post inspection) that patients with heart failure, stroke, hypertension, diabetes and COPD were receiving appropriate care and treatment according to the GP. For example 100% of patients with heart failure had an echo cardiogram and were receiving beta-blockers and 100% of all stroke patients were on a blood-thinning agent. They were audited monthly and called in if they needed a blood pressure check.

The GP did not undertake any full cycle clinical audits. There was no evidence that audits were driving improvements in performance in respect of patient outcomes.

The practice manager showed us how patient records were searched, read coded and updated. There were no specific registers kept and the searches were repeated at each required instance to ensure that no patients were missed. We asked the practice manager to show us the results from the previous few days reports but these had not been undertaken due to work pressures..

Other information such as assessments, diagnosis, referral to other services and patients at the end of their lives was

not routinely collected and monitored to show that outcomes for people were being achieved. However the GP told us that there were very good systems in place for referrals which were made appropriately. The GP told us they used the two week rule for suspected cancers and systems were especially good for referrals to the chest clinic. The prevalence of coronary heart disease, cervical screening and disease management monitoring were very low compared to the local and national averages. The GP said he put this down to the chaotic lifestyle of his population group.

The GP undertook all childhood vaccinations. The GP relied on the reception staff printing a list of those children who required immunisation. There was no formal recall system for those patients who missed appointments and no specific day in the QOF diary to follow up children who did not attend. There were no formal systems to monitor children's attendance at accident and emergency and no specific registers of looked after children or children at risk although we saw that alerts were placed on the electronic records where necessary.

We looked at the electronic record system with the practice manager. We searched for patients with a care plan in place. 20 records were returned. The GP told us they did not have care plans in place for high risk patients with a view to reducing hospital admissions or other patients with long term conditions, mental health problems or learning disabilities. The GP said they had used care plans in the past but currently had very few high risk patients.

We looked at how the reception staff dealt with repeat prescription requests. Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up the number of repeat prescriptions that were allowed and patients were asked to see the GP when this had reached its limit. Relevant medicines alerts appeared on the patient records when the GP was prescribing medicines. We saw that there was a higher than average rate for the prescription of hypnotic medicines. We asked the GP what had been done to address this and were told that the lifestyle of the patients made it difficult for them to change. There had not been any audits initiated to check whether these patients were experiencing any long term effects or whether reduction or change in their medicines was an option.

Effective staffing

Staff included the GP, practice manager, three reception staff and a part time nurse. Staff had not received any mandatory or update training in the last eighteen months. Training not completed included safeguarding, chaperoning, fire safety, infection control, health and safety, basic life support, or how to use the automated external defibrillator (AED).

The practice had a staff procedures document which provided staff with details on how to deal with practice issues and assessed their competencies in specific tasks such as how to speak to patients over the telephone, how to deal with aggressive patients, how to maintain confidentiality and how to work with the computers and filing system. We saw a blank template of this document but we were not shown any completed documents that had been signed and dated by staff to show that their competencies had been checked and they were aware of the procedures.

We spoke to the nurse who confirmed they had the appropriate level of knowledge and training to carry out their role which included giving travel vaccinations, smears, family planning discussions, dressings and hypertension checks. They did not currently undertake chronic disease management, childhood immunisations or home visits. The QOF diary instructed staff to request the practice nurse to visit patients at home if they could not attend the practice but there was no evidence that the nurse was currently equipped to do this.

A locum GP had been used only for three weeks in 2012 and for one day in 2014 when the GP had taken leave. No locum staff had been used since then and the GP had not taken any time off.

The GP's last appraisal was done on 7th July 2015 but had not yet been signed off as completed.

Working with colleagues and other services

The practice worked with some other service providers to meet patients' needs and manage complex cases, of which there were only few. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services. Most hospital correspondence was received electronically and it was reviewed by the GP prior to being filed. The GP said they would call patients to inform them of any abnormal blood results.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice received information from the out of hours service on a daily basis and undertook any actions required. They made referrals to other services appropriately, such as to cancer and chest clinics and we were given examples where referrals had been made and the outcomes for the patients had been positive.

The practice held a meeting on the last Tuesday of every month with Macmillan Nurses to discuss end of life care and make plans. The meetings were not always minuted and the information from those meetings was usually entered on to the patient record either by the GP or by the practice manager. The GP also had telephone discussions with other health and social care professionals about patients who required a multi-disciplinary approach to their care. The GP did not offer any evidence about how that information was used, but we were told that the numbers were very small. The GP was not aware of any information that might be shared with ambulance services.

Consent to care and treatment

The practice manager told us that children under 12 were not normally seen unaccompanied, unless in exceptional circumstances, such as if there were any concerns. The GP confirmed that the vast majority of females under the age of 16 attended the practice with their mother. The GP did not offer any examples where they would use (or had used) Gillick competencies. Gillick competencies help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. When we spoke to the nurse they were aware of Gillick competencies but had not needed to use them to assess any patients at this practice.

Neither the GP nor any other staff at the practice had formal training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The GP offered no examples where a patient's mental capacity or ability to consent to treatment was, or had been an issue. We discussed language barriers and were told that an on-line translation service could be used and translators could be booked.

We saw that patient general directives were used by the practice nurse when giving vaccines (such as travel vaccines) and we saw that patients had signed these directives to confirm their consent to receive treatment.

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The CQC comments cards we reviewed did not highlight any issues with consent.

Health promotion and prevention

Good health was promoted opportunistically. The GP told us that they found health promotion difficult because all avenues had been explored and his patients did not want to make changes.

The practice did not have a website and there were no leaflets or posters in the waiting room or treatment rooms with advice, signposting or other support opportunities for patients. There was nothing for example on smoking cessation, diet and fitness, mental health issues, sexual health issues, counselling and bereavement services or advice about long term conditions and self management. A notice in the patient toilet informed patients private Botox treatment was available at the practice.

Child immunisation rates were lower than the national average. For babies aged up to 12 months the results ranged between 92% and 96%. The national average ranged between 96% and 97%. For babies aged up to 24 months the figures ranged between 92% and 100% against the national average of 94% to 97% and for those aged 5 years the rates were lower than the national average. They ranged from 90% to 93% against the national average of 89% to 97%.

The percentage of patients receiving flu vaccinations was similar to expected at 74% against the national average of 73%. Patients aged 65 and older who received a seasonal flu vaccination was also similar to expected at 48% for the practice against the national average of 52%.

We asked for a practice leaflet. It contained information of the practice opening times, services provided and what to do when the surgery was closed. There was a directory at the back of the leaflet with telephone numbers for a myriad of services which would be helpful to patients including drug and alcohol services. However, the patient leaflet was not on display in the waiting room and had to be requested. The practice manager told us that new patient health checks were offered to all new patients and there was a system in place to facilitate this. We did not receive any evidence of the number of new patients who had received this service. The checks were offered by the GP or the nurse, whoever was the first person to see the patient.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The staff we spoke with told us they understood their patient population group and people's cultural, social and religious needs. They reported that the population was diverse and they knew all their patients well. We observed that people were known and addressed by their first names and were treated in a respectful, dignified and compassionate manner.

We looked at the results from the most recent GP survey. There were 439 survey forms distributed for the practice and 108 forms were returned which gave a response rate of 24.6%. 81% of patients reported that the last GP they saw or spoke to was good at treating them with care and concern. This was slightly lower than results reported for the local and national average at 85%. 85% said the same about the nurse which was also lower than the local and national average at 90%.

Staff took time to interact with the people who used the services and were helpful and supportive when offering advice and information.

The waiting room was very small and there was little or no privacy. We saw that reception staff were careful not to reveal any confidential information and no breaches were overheard during our visit. We were told that there was a private room available where patients could speak confidentially if they wished, but there were no signs informing patients of this.

Doors were closed during consultations and no conversations could be overheard. All of the patients spoken to and all of the comments on the CQC comments cards gave positive comments about respect and dignity. We were told by the practice that a chaperone service was available but there were no signs in the waiting room or consultation rooms to notify patients of this. We saw that privacy curtains were used around treatment couches and a patient said that a receptionist had been present as a chaperone when one had been required.

Care planning and involvement in decisions about care and treatment

Results from the patient survey showed that the 81% of patients said the last GP they saw or spoke to was good at explaining tests and treatments compared to the local average of 87% and national average which was 86%. 78% thought the GP was good at involving them in decisions about their care which was lower than the local average of 84% and national average of 81%.

Discussions with staff assured us that they understood that the way patients were supported had an impact on their care, treatment or condition. The GP had worked at the practice for more than 25 years and knew all the patients and their families very well. They told us that patients were involved in their care as much as they wanted, or were willing to be. We were told that options, and pros and cons of treatment were discussed.

There was a hearing loop in reception for the hard of hearing and the GP said that they used reading and signs to communicate with patients who were deaf or hard of hearing. There was nothing in the waiting room about information available in different languages or interpretation services although we were told that there were arrangements in place for people whose first language was not English. Reception staff told us about interpretation services but said they were infrequently used as patients who could not speak English brought members of their family to interpret for them.

Patient/carer support to cope emotionally with care and treatment

We spoke to 14 patients on the day of the day, many of them had been with the practice more than twenty years and their families were also patients there. All the patients without exception held the GP and the practice in high regard and the comments on the CQC comments cards were also positive. Patients said they were very well supported, were very happy with the access and were happy with the staff.

There was nothing formal in place to support patients and/or their relatives who were recently bereaved or receiving end of life care. However the GP stressed that the service was very personalised and support was offered in a family orientated way whenever it was required. A patient told us how well they had been supported following the death of their husband.

There was no information about other support services in the area, displayed in the waiting room or in any of the

Requires improvement

Are services caring?

treatment rooms. A telephone directory was available at the back of the practice leaflet but the practice leaflet was not on display at reception and we had to ask staff for a copy.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Although the GP told us that they knew their patient population and was responsive to patient needs, we found the practice did not have effective systems in place to respond to the needs of the various population groups. For example the number of female patients between the ages of 20 and 50 years was higher than the England average. The uptake at the practice for cervical smears was 62% which was lower than the national average of 81%. When we discussed this with the GP they said they had a system in place and had no idea why the uptake was low other than the chaotic lifestyle of the patients concerned.

The GP and the practice manager attended the South Manchester Clinical Commissioning Group (CCG) Didsbury, Burnage and Chorlton patch meetings six times a year. The GP reported that they attended these meetings as part of their appraisal requirements.

The practice was signed up for a direct enhanced service to involve patient participation. However there was no patient participation group and the practice did not make changes to the service based on any feedback received from patients.

The practice had a very high prescribing rate of hypnotic and antibiotic medicines. The rates were almost three times higher than the national average and we were told this was due to the chaotic lifestyle of some of the patients registered at the practice. When we discussed this with the GP they told us the patients had been on these medicines for a long time and did not want to reduce or make changes. This meant that the patients continued to receive the medicines that met their requirements but not necessarily those that were in their best interests.

The practice manager told us that the practice was aware of some negative feedback left on the NHS Choices website but had declined to provide any response. They had not done anything with the information.

Tackling inequity and promoting equality

The GP told us the practice recognised the needs of different groups in the planning of its services. A very low percentage of patients did not speak English as their first language but a translation service was available if required. In addition the GP told us they would use an online translation service to transpose text into different languages. Staff had not received formal training in equality and diversity but those we spoke with told us that all patients were treated equally.

The practice could identify certain groups of patients such as those who were housebound, required additional help, had or were a carer or had a learning disability. They did this by searching for key words on the electronic computer system, but we did not see specific registers of these patients. We asked the GP how they worked with patients who had dementia or learning disabilities. The GP said that they were happy to provide care and involve these patients but if mental capacity became an issue and they found themselves in a difficult situation they would signpost the patient to more appropriate and supportive services. The GP and practice staff were not trained in mental capacity, deprivation of liberty safeguards or dementia.

Access to the service

The practice was open Monday to Friday from 8.30am until 6pm except Wednesdays when they closed at 1pm. The GP operated an open morning surgery from 9.15am until 11.30am and no appointments were required. An evening surgery was available (except Wednesdays) between 4.20pm and 5.30pm and could be accessed via appointment only. A part time practice nurse worked three hours per week on a Friday and patients were able to see her by appointment. A phlebotomist attended the practice weekly on a Tuesday and appointments were made through the receptionists. The GP provided telephone advice after morning surgery and made home visits to patients who were housebound. All home visits were carried out on the day of request, however the GP assessed the patient firstly on the telephone to see if a home visit was necessary.

Information was available to patients about appointments in the practice leaflet. There was no website. Information included how to arrange urgent appointments and home visits and how to request prescriptions. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Information about how to make a complaint was available in the patient leaflet. It stated that there was a formal complaints procedure and details were available on request. The information was not readily available in the waiting room.

We asked the practice manager and the GP about complaints made to the practice and were told that very few were received. The GP told us that a response was dependent on the situation. If a patient reported concerns during consultation then the GP would discuss those with them. If a formal complaint letter was received the practice manager would arrange a meeting. The GP reported that complaints were mostly sorted informally. Those informal comments and discussions were not logged anywhere other than on the patient record. The GP confirmed that there were a small number of patients on the practice list who had complained but they had not wanted to leave the practice because of the responsive service they received.

Reception staff also reported that complaints were dealt with informally as and when they happened and were not formally recorded anywhere other than on the patient record. No complaints were formally reported, recorded, reviewed or monitored to check for any trends which might identify changes the practice could make to improve the services offered.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The purpose of the practice was set out in their statement of purpose. It offered patients personal health care of a high quality. It outlined the practice objectives which included the development and improvement of patient pathways, reduction in waiting lists and management of patients in primary care through specialist advice and feedback.

We asked the GP and the practice manager about their future vision, how they monitored the objectives in the statement of purpose and if they had a five year succession plan should the GP retire.

We were provided with no evidence during the inspection that showed the objectives in the statement of purpose were monitored and reviewed. There were no plans for any changes in the next twelve months or in the next five years. There were no plans to introduce a salaried and the practice intended to continue as it was until the lease of the premises expired in the next few years. The GP told us that at that point a decision would be made about its future.

All the staff we spoke to said that they offered a good responsive service to their patients and felt that all the patients were very happy with the service they received. They aimed to continue providing this service in a positive way.

Governance arrangements

The governance arrangements did not demonstrate a clear and systematic approach to identifying and mitigating risks. Processes were disorganised, were not managed consistently and were not recorded in a way to monitor performance. The GP worked in isolation to care for their patients and did not recognise a benefit or necessity of recording information about the performance of the practice for himself.

Formal recording of significant incidents and comments and complaints was not enforced and there was nothing to evidence that monitoring, trends, actions and learning took place. The GP had learned that he had been giving incorrect advice about nasal steroids for many years, but this had not been recorded as a significant event. The GP received concerns, comments and complaints during consultations, but these were not formally recorded using a system where they could be monitored. Full cycle clinical audits were not carried out.

The GP used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data from 2013-2014 for this practice showed it was generally performing in line with national standards but had been lower than national standards in the prevalence of coronary heart disease, cervical screening and diabetes management. The GP put these low figures down to the lifestyle of the patients and was unable to tell us of any actions that had been taken to address the low prevalence, other than systematic recall of the patients.

There was no system to keep policies and procedure documents under review. Electronically accessible policies were not in line with paper copies and policies such as infection control and health and safety were not aligned with working practice in relation, for example, to training and the duties to be carried out by staff. These included the monitoring of medicines and the calibration and safety testing of equipment. The policies we looked at did not have dates to show when they were created, whether or not they had been signed off by the GP, and when they were last reviewed.

Leadership, openness and transparency

The management structure for the practice comprised of a single handed GP who held the managerial and financial responsibility for the practice. They were supported by a practice manager, a part time nurse and three reception/ administration staff. The GP told us they looked after patients and the practice manager was responsible for everything else.

No team/staff meetings took place where the GP got together with the other staff. The GP worked in isolation. This meant that staff did not have formal discussions, with an agenda, that they could plan and prepare for. The reception staff however reported that the GP and the practice manager were both very approachable and they would not hesitate to discuss any matters with either of them. They all spoke on a daily basis and the practice manager met more formally with the GP on a weekly basis when they discussed operational practice, budgeting and

Are services well-led?

Inadequate

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

contracts. Some information, such as emails from the CCG were sent in advance of the meeting. None of the meetings were minuted and there was no way to evidence what had been discussed at any given time.

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

The practice were involved in a direct enhanced service which aimed to encourage GPs to obtain the views of patients through a patient participation group (PPG). The GP told us that although they had tried to set up a PPG their attempts had not been successful. We were not shown what avenues had been explored to encourage patients to be a part of this group but were advised that due to the nature of the patients it was not something that they would be interested in.

The practice had undertaken a patient survey in June 2015 and received the views of 37 patients which was just under 1% of the practice population. The results were mostly positive and the GP had concluded that the patients were happy with the service. The questions related solely to the treatment by the GP and did not go into anything else about the practice such as the reception staff, privacy, services offered and the environment.

Management lead through learning and improvement

The GP was appraised annually. Their last appraisal was in July 2015 and this had not yet been signed off. The GP appraised the practice manager annually and had no issues about their performance. No training needs had been identified and planned. The practice manager appraised the other members of staff, including the nurse, and there were no issues about their performances. No training needs had been identified and planned.

The GP told us that they only attended meetings required as part of their appraisal process. This included a multidisciplinary discussion with other health and social care professionals monthly, about any patients at risk and a patch meeting with the CCG. The GP did not undertake any regular peer discussions or information sharing such as referral reviews, significant events, audit or training opportunities. We were told that the practice did what they needed to do and did not have the time to document what went on. This meant there were no opportunities to learn from things that went wrong and staff were not encouraged to improve the service they provided by improving themselves and their knowledge.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. The provider did not ensure systems were established and operated effectively to prevent the abuse of service users. Specifically, the practice had not provided safeguarding training at the required level to all staff. Regulation 13 (2).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance The registered person did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others Seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purpose of continually evaluating and improving the services. Evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e) of the Regulation Regulation 17 (1) (2) (a) (b) (e) (f)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The provider did not employ suitable numbers of qualified staff to provide an effective service. Staff did not receive appropriate support, training and professional development to enable them to carry out the duties they were employed to perform. Staff were not enabled to obtain further qualifications appropriate to the work they performed. Health and medical staff were not able to evidence that they continued to meet the professional standards which are a condition of their ability to practice; Regulation 18 (1) and (2) (a) (b) and (c)

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment Care and treatment must be provided in a safe way for service users. The provider did not assess, manage and respond to risks appropriately, The provider did not check that all equipment was safe and in good working order; The provider did not manage medicines safely; The provider did not assess, prevent, detect and control the spread of infection appropriately; Regulation 12(1) (2) (a) (b) (e) (g) (h)